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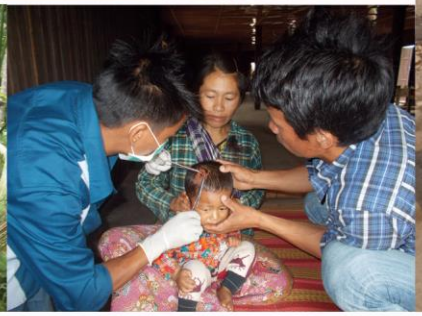
BPHWT
annual report
2015







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Glossary of Terms

ACT	Artemisinin-based Combination Therapy
AMW	Auxiliary Midwife (under the Burma government structure)
ARI	Acute Respiratory-tract Infection
BBG	Burma Border Guidelines, the standard guidelines for diagnosis and treatment on the Thailand/Myanmar border
BPHWT	Back Pack Health Worker Team
CBO	Community-Based Organization
CSO	Civil Society Organization
CHEPP	Community Health Education and Prevention Program
Confirmed malaria	Malaria diagnosis confirmed with a Rapid Diagnostic Test
CHW	Community Health Worker
EHO	Ethnic Health Organization
EmOC	Emergency Obstetric Care
FIC	Field in-Charge
FPIC	Free, Prior and Informed Consent
HCCG	Health Convergence Core Group
HID	Health Information Documentation
HIS	Health Information Systems
HPCS	Health Program Convergence Seminar
HRV	Human Rights Violation
IDP	Internally Displaced Person
ITN	Insecticide-Treated Net
Joint funding	Funding of border-managed and Yangon-managed organizations
KIA	Kachin Independence Army
KIO	Kachin Independence Organization
KNLA	Karen National Liberation Army
KNU	Karen National Union
EAROs	Ethnic Armed Resistance Organizations
M & E	Monitoring and Evaluation
MCP	Medical Care Program
MCHP	Maternal and Child Healthcare Program
MDA	Mass Drug Administration
Pf	Plasmodium falciparum, the most deadly type of malaria parasite
PLA	Participatory Learning and Action
Pv	Plasmodium vivax, another type of malaria parasite
RDT	Rapid Diagnostic Test, used for diagnosis of plasmodium falciparum malaria
Tatmadaw	Burma Army
TBA	Traditional Birth Attendant
TMO	Township Medical Office (under the Burma government structure)
TNLA	Ta'ang National Liberation Army
TTBA	Trained Traditional Birth Attendant
TOT	Training-of-Trainers
VHV	Village Health Volunteer
VHW	Village Health Worker
WHO	World Health Organization
KBC	Karen Baptist Convention

Part I: 2015 Annual Report

1) Executive Summary

The Back Pack Health Worker Team (BPHWT) is a community-based organization that has been providing primary health care for fifteen years in the conflict and rural areas of Burma, where access to quality free/affordable primary healthcare is otherwise unattainable. The BPHWT provides a range of medical care, community health education and prevention, and maternal and child healthcare services to internally displaced persons (IDPs) and other vulnerable community members in Burma.

Doctors and health workers from Karen, Karenni, and Mon States established the BPHWT in 1998. The organization initially included 32 teams, consisting of 120 health workers. Over the years and in response to increasing demand, the number of teams has gradually increased.

Providing Health Service to Populations in Remote Areas

In 2015, the BPHWT consisted of 100 teams, with each team being comprised of three to five trained health workers who train and collaborate with five to ten village health workers/volunteers and five to ten trained traditional birth attendants; this network of mobile health workers with advanced skills and stationary health workers with basic skills ensures that community members have consistent access to essential primary healthcare services. Within the 100 Back Pack teams, there are now 37 stationary teams, called Public Health Centers (PHCs). These PHCs, formerly mobile Back Pack teams, were established during 2013 in areas within Shan, Karenni, Karen, and Mon States and Tenasserim Region which are experiencing more stability and security. The PHCs provide both treatment and preventative health care, and a secure facility to store medicine and medical supplies/equipment.

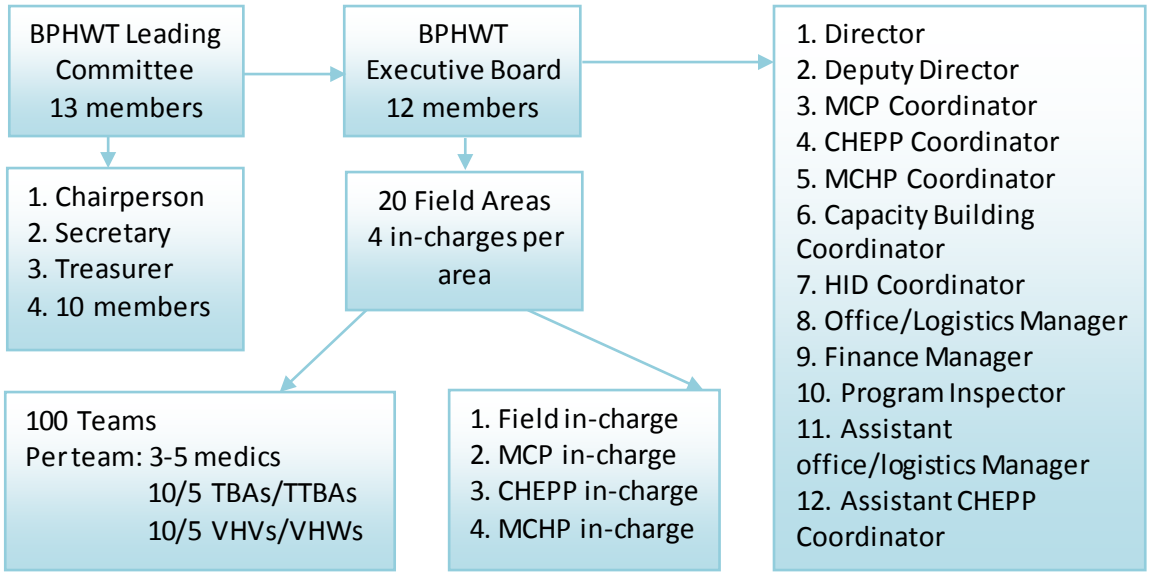
The BPHWT teams target displaced and vulnerable communities with no other access to healthcare in Karen, Karenni, Mon, Arakan, Chin, Kachin and Shan States, and Pegu, Sagaing and Tenasserim Regions. The teams deliver a wide range of healthcare programs to a target population of almost 244,410 IDPs and other vulnerable people. The BPHWT aims to empower and equip people with the skills and knowledge necessary to manage and address their own health problems, while working towards the long-term sustainable development of a primary healthcare infrastructure in Burma.

In 2015, the BPHWT continued to work with communities in its target areas to implement its three health programs, namely the Medical Care Program (MCP), Maternal and Child Healthcare Program (MCHP), and Community Health Education and Prevention Program (CHEPP). The BPHWT encourages and employs a community-managed and community-based approach where health services are requested by communities and the health workers are chosen by, live in, and work for their respective communities.

2) Organizational Structure and Governance of the BPHWT

The Back Pack Health Worker Team is led by a Leading Committee, consisting of a Chairperson, Secretary, Treasurer, and ten other members. This committee provides overall guidance, and determines the principles and policies of the BPHWT. The Leading Committee appoints the Executive Board, which is composed of the Program Directors and Program Coordinators of the BPHWT.

2.1) Organizational Structure of the BPHWT



Governance: As depicted in the Organizational Structure, the BPHWT is governed by the Leading Committee elected by the BPHWT members. The Leading Committee is comprised of 13 members who are elected for a three-year term. The Leading Committee appoints all 12 members of the Executive Board, which is required to meet monthly and make decisions on current issues faced by the BPHWT. The BPHWT has a range of organizational documents that guide the leadership, management, healthcare delivery, health information systems and human resources of the organization. Full copies of any of these organizational documents are available upon request.

The BPHWT Constitution: The Constitution provides the framework for the operation of the BPHWT through thirteen articles that define the organization's name, vision, mission statement, organizational identification, symbol, goals, objectives, policies and principles, actions and implementation, monitoring and evaluation, membership, election of the Leading Committee, amendments to the Constitution and organizational restructuring, employment of consultants and job descriptions for positions.

2.2) Financial Management and Accountability: The BPHWT has developed policies and procedures guiding the Leading Committee, Executive Board, Program Coordinators, Office Staff, and Field Staff in terms of financial management and accountability, the production of annual financial reports, and the requirement for an annual independent audit. These documents establish the financial records to be kept; the management of bank accounts; the procedures for cash withdrawals, deposits, transfers, receipts, disbursements and general administration funds; and the liquidation of cash assets. The BPHWT has also developed policies covering payments for lodging, travel and honoraria for services rendered.

2.3) Vision: The vision of the Back Pack Health Worker team is targeting the various ethnic nationalities and communities in Burma to be happy and healthy society.

2.4) Mission: The Back Pack Health Worker Team is organized to equip people with the skills and abilities necessary to manage and address their own healthcare problems, while working towards the long-term sustainable development of a primary healthcare infrastructure in Burma.

2.5) Goal: The goal of the Back Pack Health Worker Team is to reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary healthcare.

3) Gender Policy and Analysis

In 2015, the participation of women in the Back Pack Health Worker was 57 % excluding Traditional Birth Attendants/ Trained Traditional Birth Attendants (TBAs/TTBAs). The organization has a gender policy which aims to improve equity for women across all levels of the organization. The table below depicts the current targets and actual percentage of women across organizational tiers. To date, the BPHWT meets or exceeds all gender equity targets for the various organizational tiers.

Table 1: Gender policy

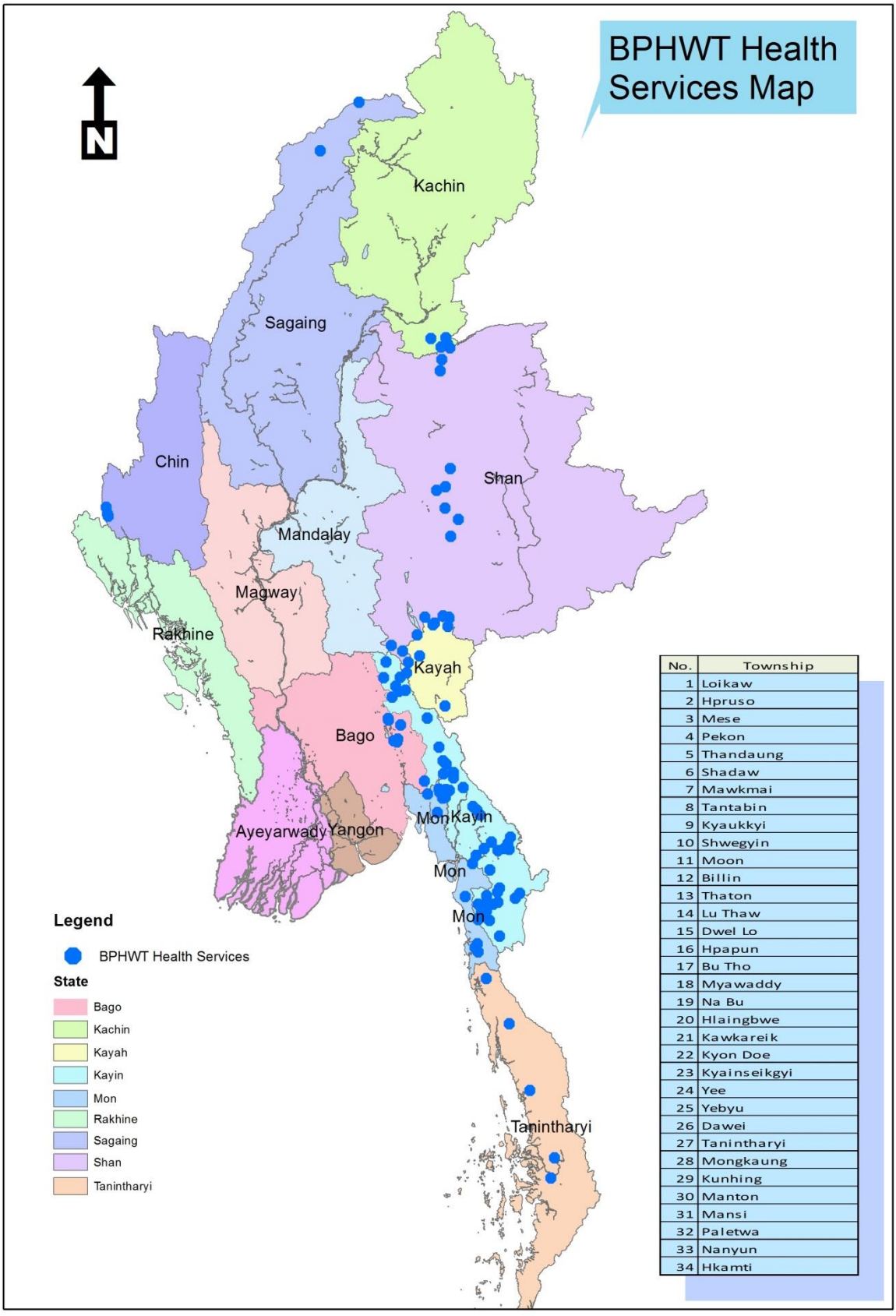
Gender Policy and Analysis Table – 2015			
Category	**Total Workers**	**Total Women**	**Actual Women %**
Leading Committee/Executive Board	15	6	40%
Office Staff	17	5	29%
Field Management Workers/FICs	61	27	44%
Field Health Workers	298	155	52%
Trained Traditional Birth Attendants	741	675	91%
Village Health Workers	215	150	70%
Organizational Total	1,347	1,018	76%
Total Organization excluding TTBAs			**57%**

Service System: Since 1998, the Back Pack Health Worker Team has been working towards developing an accessible, community-based, primary healthcare service system within the BPHWT field areas, based on the health access indicators.

4) Health Access Targets for a Community-Based Primary Healthcare System

Population	Health Service Type	Health Workers	Ratio (Workers/Pop)	Ideal Number of Workers
2000	BPHWT (Community-based primary healthcare unit)	Health Worker	1:500	4
		Traditional Birth Attendant/Trained Traditional Birth Attendant	1:200/400	10/5
		Village Health Volunteer/Village Health Worker	1:200/400	10/5
Total Members Per Team				**24/14**

5) Map of Operational Areas



No.	Township
1	Loikaw
2	Hpruso
3	Mese
4	Pekon
5	Thandaung
6	Shadaw
7	Mawkmai
8	Tantabin
9	Kyaukkyi
10	Shwegyin
11	Moon
12	Billin
13	Thaton
14	Lu Thaw
15	Dwel Lo
16	Hpapun
17	Bu Tho
18	Myawaddy
19	Na Bu
20	Hlaingbwe
21	Kawkareik
22	Kyon Doe
23	Kyainseikgyi
24	Yee
25	Yebyu
26	Dawei
27	Tanintharyi
28	Mongkaung
29	Kunhing
30	Manton
31	Mansi
32	Paletwa
33	Nanyun
34	Hkamti

6) General Health Situation in Burma

Health in Burma is another casualty of decades of military misrule, ethnic conflict, centralized decision making, and the exodus of qualified health professionals. Thus, there has been, and continues to be, a shortage of qualified physicians, nurses, midwives, and community health workers as well as inadequate medicine, medical equipment, and hospital/clinic beds. Hospital facilities are run down and require renovation. The reliability of electricity in health facilities is a constant problem. Also, people living in armed conflict and remote areas have no reasonable access to health care within a few days' walk. Many rural and urban areas lack clean water and proper sanitation. There is no real Union government health care scheme and patients must pay for medicine, food, blankets, and bribes to medical personnel.

Consequently, Burma has some of the worst health indicators in the world. Its maternal and child mortality health indicators rank among the worst in Asia. Burma continues to register the greatest number of malaria deaths and the highest malaria fatality rate of any country in Southeast Asia. The main causes of morbidity and mortality in the country are overwhelmingly preventable from diseases such as malaria, malnutrition, diarrhea, acute respiratory infections, tuberculosis, and HIV/AIDS.

The National League for Democracy (NLD) has won the 2015 elections and will control both the Executive and Parliamentary branches of government beginning in 2016. Little is known of its plans for the health sector, especially health sector reform. However, some of its health priorities are indicated in the NLD's ***2015 Election Manifesto*** as quoted in here below:

The following activities will be carried out for the emergence of a universal healthcare system:

1. We will improve and expand basic healthcare provision.
2. We will implement projects to reduce maternal and infant mortality, and we will strive to prevent malnutrition and ensure access to medicine.
3. We will bolster school health initiatives in order to encourage good health-related practices, improve knowledge of health issues, and reduce the spread of infectious diseases among our children and young people, so as to support their healthy development.
4. We will cooperate with civil society organisations on awareness-raising programmes for young people on the dangers of drugs, and we will carry out more effective treatment and rehabilitation programmes.
5. We will develop programmes for healthcare provision for the elderly and for people with disabilities, and we will aim to raise the average life expectancy above 64 years.
6. We will implement infectious disease prevention programmes, focusing in particular on reducing the incidence of tuberculosis, malaria, hepatitis, and HIV, and we will strive to ensure that there are sufficient drugs for treatment.
7. For non-communicable diseases with harmful health impacts, such as diabetes, high blood pressure, and heart disease, we will reduce the levels of incidence through prevention programmes.
8. We will aim to enable government hospitals and clinics to provide high-quality drugs and modern treatment methods, raise the qualifications of government health staff (including doctors, nurses and midwives), and ensure that healthcare is provided in accordance with ethical standards.
9. We will permit, in accordance with the law, the opening of private hospitals and health clinics, in order to further improve public health.
10. We will cooperate with international experts and organisations in order to develop and improve drug production, treatment, medical teaching, and research programmes.
11. We will systematically improve healthcare management systems based on accurate data and information.
12. We will implement emergency healthcare programmes for areas affected by natural disasters, and dedicated healthcare programmes for remote and hard-to-reach ethnic areas.
13. We will promote the further development and improved study of traditional medicine.
14. We will systematically strive to prevent people from inadvertently using harmful western and traditional medicines and consuming potentially harmful foods, water and other drinks.
15. We will increase the national health budget, and enable a reduction in the level of out-of- pocket expenditure incurred by the public for medical treatment.

From the ethnic health perspective, what is obviously missing from this Manifesto is a NLD commitment toward a devolution of health sector political, administrative, and fiscal authority and responsibilities to sub-Union levels. While the ethnic health organizations and ethnic health community based organizations have been invited to share information about their health systems, structures, programs, and policies, they have yet to be invited to have a "seat at the table" to participate in health sector reform. This is not only important from an ethnic health sector perspective, but also would be a confidence building measure by the NLD to the ethnic people showing that the NLD considers them to be an important participant in reshaping the social, economic, and political landscape of Burma/Myanmar to include all ethnic groups on an equal basis.

7) General Health Situation of Internally Displaced Persons

The Internal Displacement Monitoring Centre estimates that up to 400,000 people may be internally displaced in southeastern Burma and up to another 100,000 internally displaced persons (IDPs) in Kachin State and Northern Shan State. Armed conflict, human rights abuses, and development-induced displacement continue to be the key underlying factors for these large numbers of IDPs.

Providing Healthcare to IDP populations

While the health indicators of Burma's population rank amongst the poorest globally, the health of IDPs within Burma is even a more serious cause for concern. Health indicators for the rural ethnic and IDP populations in eastern areas of the country are demonstrably worse than Burma's national rates. IDPs face harsh living conditions in the jungle: their means of survival are a constant challenge. In addition to dealing with the burden of protracted conflict and the high frequency with which they are forcibly displaced, access to state healthcare systems is either extremely limited or non-existent.

IDPs, living in temporary or semi-permanent sites, have increased health risks due to inadequate sanitation, poor hygiene conditions and limited access to safe water. During the rainy season, the water borne disease situation becomes worse with pit latrine overflows and flooding in places around these sites used for open defecation places. Consequently, they face critical health challenges resulting in high morbidity and mortality rates attributable to largely preventable diseases such as diarrhea, malaria, and acute respiratory infections.

Until there is a durable peace in the ethnic areas, there will be the continuing need for primary health care for the IDPs and other vulnerable people which can only be currently met through the ethnic health organizations, not through the Burma Government.

8) Current Political Context

During this period, the Burma Government and the ethnic armed organizations (EAOs) were actively engaged in talks about a Nationwide Ceasefire Agreement (NCA). In October, eight EAOs signed the NCA with the Burma Government. However, the Burma Government has refused to enter into any ceasefire agreement with three EAOs whom it wishes to defeat on the battlefield. Thus, the remaining EAOs with temporary ceasefire agreements in place did not sign the NCA as they felt that it should include all EAOs. After the signing of the NCA, the NCA signatories met to develop a Framework for Political Dialogue as well as to form various committees to organize a Union Peace Convention and for joint ceasefire monitoring.

Also, elections were held in Burma in November with the National League for Democracy (NLD) winning a majority of seats in both the upper and lower houses of the Union Parliament. This allows them to form a new government and choose the next president of the country as well as one of the two vice presidents. Under the 2008 Constitution, the Burma Army will choose the other vice president.

Due to a provision in the 2008 Constitution, Daw Aung San Sui Kyi cannot become president. She has stated that despite this, she will be above the NLD-chosen president. This proxy presidential situation has raised some concern to her stated commitment to the rule of law and democracy as well as to the efficient functioning of an NLD-led government.

Unfortunately under this same Constitution, the Burma Army does not report to the President. It is an independent branch of government. With six of the eleven members of the National Defence and Security Council (NDSC) from the Burma Army or appointed by the Burma Army, it also controls decisions on key security issues. Through it 25% of the members of the Union Parliament, the Burma Army controls changes to the Constitution. Lastly, the government civil service bureaucrats from the Union level down to the township level are all employees of the Union Ministry of Home Affairs, one of the three Union ministries allocated to the military. Thus despite the win of the NLD, the Burma Army still controls most of the key levers of power.

Added to all of this is that the NLD did not win a majority of the seats in two state parliaments. Yet, the NLD has indicated that it will choose the chief executives of those states instead of acting on the recommendations of the ethnic parties that did win a majority in those two states. This has resulting in some friction between the NLD and some ethnic political parties.

9) Security Situation in the BPHWT's Target Areas

Active conflicts continue in Shan State with the Burma Army mounting offensive military operations against the Ta'ang (Palaung) National Liberation Army (TNLA). Also, clashes have occurred in Arakan State between the Burma Army and the Arakan Army (AA). The Burma Government has no ceasefire agreements with either the TNLA or AA. These continuing offensive operations by the Burma Army against the TNLA have increased the number of internally displaced persons (IDPs) in Northern Shan State.

As a consequence of the various ceasefire agreements concluded over the past three years with various EAOs, the security situation has generally improved elsewhere in the BPHWT target areas with greater freedom of travel for Back Pack health workers.

10) Obstacles and Threats to Delivering Health Care in the BPHWT's Target Areas

The obstacles and threats to the delivery of essential medical treatment and health workshops by our teams in the Palaung areas of Northern Shan State are of special concern with almost daily fighting between the Burma Army and EAOs as well as the encroaching presence of the Burma Army. Further, Back Pack teams in the conflict areas Shan State are especially active in addressing the additional health situations resulting from the ongoing fighting and internal displacements of people and fighting.

On 23 January 2016 in the Pa An Field Area, the Naung Kai Back Pack Team reported that the fighting in upper Kaw Mou village resulted in a villager getting wounded in his back. In response, Back Pack health workers tried to refer him to Kawkareik Hospital for immediate treatment: this was refused by the BGF. He was then successfully treated in the village. This incident could be construed as a violation of medical neutrality under international law which forbids obstructions to the delivery of health care.

During this period in the Palaung Field Area, there has been an increased level of fighting between the Burma Army and ethnic armed organizations (EAOs) which has resulted in a negative environment for health workers and the communities they serve in this field area. Freedom of travel for the health workers is restricted due the continuous fighting. On 12 November 2015 the Palaung Back Pack Team encountered Burma Army Brigade 77 in the Taw Nay Back Pack area. The Team was forced to flee and leave behind some of its supplies and forms.

For two days later in December 2015 in this Palaung Field Area, the Burma Army attacked the Ta'ang National Liberation Army in Lai Sai village tract around Si Lu Gyi village. Due to the fighting, every household dug into the ground to protect themselves from the artillery and other shelling. Moreover, when the Burma Army came to this Palaung Back Pack area, the health workers also dug into the ground to hide and store their documents and supplies. The health workers dared not sleep in the clinic during these periods of shelling and fighting.

Moreover Back Pack health workers in its field areas continue to contend with the environment of landmines, weather, and difficult terrain in providing their health services, especially to those in conflict areas and displaced from their villages.

11) Human Rights Abuses and Environmental Health Hazards in the BPHWT's Target Areas

During January 2016 in the Arakan Field Area, there was fighting between the Arakan Army and the Burma Army Light Infantry Battalions (LIBs) 376, 375, 374, and 539 in Pon Nar Kyon. Due to this fighting, local villagers fled from the village, leaving their agriculture and property. Also, the Burma Army made arbitrary demands for laborers. Moreover, a Burma Army soldier shot and wounded one villager, who lives in Kyi Yar Pyin village, Myok Oo Township, in the hand.

Additionally in the Arakan Field Area, the Burma Government and the China National Petroleum Corporation began gas production on Yanbye Island of Kyauk Phyu Township. People in the local communities had their land forcibly confiscated and are receiving no benefits from this mega-project. Local fishermen are not allowed to catch the fish near the gas production project. All of this results in the loss of daily wages and livelihoods in the affected communities.

There is a great problem with land confiscation and human rights abuses in the Hukawng Valley area in the Kachin Field Area from 2007 to the present due to the activities of the Yuzana Company. Over this period, the Company has confiscation 200,000 acres of land in this area for large scale sugar cane and tapioca production, providing unfair compensation and poorly constructed housing for displaced villagers. Also, the Company hires their workers from Yangon and other places outside the area. Villagers have tried to apply for jobs, but the Company has denied their applications. Thus, the displaced villagers have no daily income, and face food and other related livelihood problems. Additionally, local women face gender based violence with instances of rape during 2015, the Burma Army has erected checkpoints and is stopping everyone, and drug abuse is becoming more prevalent – all as a direct result of this project.

The Naung Kai Back Pack Team in the Pa An Field Area reported the following:

- Between November 2015 and February 2016, Border Guard Force (BGF) Brigades 1017 and 1016, and Burma Army LIBs 548, 547, 549, and 230 conducted operations in both Hlaingbwe and Kawkareik Townships. In Thi War and Noy Bay villages, the LIB soldiers bullied the villagers to give them alcohol, chicken, and some vegetables without any payment of money.
- On 25 January, 2016, the local BGF and the Burma Army burnt down Pyar Pin village in Kawkareik Township – only one house was left in the village. Villagers quickly fled to Kyar Shar Koon village; but some families are still split and not together.
- On 2 February 2016, a local BGF burned a villager's rubber plantation because they accused the plantation of proving rations and other support to the Democratic Karen Buddhist Army (DKBA).
- On 3 February 2016, the local BGF arrested a villager and his son, who live in Kyar Shar Koon village, for allegedly supplying rations to the DKBA. The BGF finally released the father, but continued to detain the son.
- From December 2014 to March 2015, a local BGF began Gaw Dan stone mining in Ka Law Jay Ta village, destroying rice farming areas. The BGF gave 300,000 kyats in compensation which was inadequate and unfair. However, before this mining, rice farming was able to product four tons; but now they can produce only two tons. The villagers don't like this situation, but they are afraid to confront the BGF about this.

On 16 March 2016 in the Palaung Field Area, Burma Army Brigade 77 arrested fifty-five villagers from Pa Hlaing village. In response, a monk from the village requested the Burma Army to release them. The Burma Army only released thirteen villagers, but continued to detain the remaining forty-two villagers. The monk then asked the Burma Army to release the remaining villagers. The Burma Army responded by demanding 50,000 kyats per day for the release of the detained villagers. To comply with this demand, the monk asked each household in the village to contribute 5,000 kyat. However, the villagers are very poor and had difficult to give this amount of money. The monk told the Burma Army about the villagers' financial situation. The Burma Army did not like this reply and continued to detain the villagers, but did not torture them. They further said that they would not release the villagers unless ordered to do so by their Burma

Army commanding major. This period is very important for the villagers as it is the time for harvesting their green teas to get income for their families.

12) Special Situations in the BPHWT's Target Areas

The BPHWT participated in a number of emergency assistance operations during 2015 period as a member of Emergency Assistance and Relief Team (EART). The EART is the emergency response unit of the Forum for Community-based Organizations of Burma (FCOB), a collective of Burmese civil society organizations operating along the Thai-Burma border. It aims to assist Burmese people who are in need due to natural or manmade disasters through the provision of food, water, shelter, clothing, health services, and rehabilitation. This is provided by working directly with the affected communities who are not receiving aid or not receiving sufficient aid from the Burma Government or INGOs.

On 22 June 2015, the EART provide immediate assistance to persons internally displaced due to land confiscation in Upper Kop Yin, eighteen miles from Myi Ka Lay Village in Pa An Township, Karen State, Burma/Myanmar. As a result of the land confiscation, the houses of the villagers were destroyed, leaving them with only some personal items. In response, the EART delivered the emergency rations and supplies including rice, cooking oil, mats, blankets, and mosquito nets. The beneficiaries of the EART emergency assistance were eight-three households consisting of three hundred ninety-three persons. In this emergency relief operation, the EART collaborated with the 88 Karen Generation and local villagers as they were quite familiar with the local geographic and security situation.

Fighting on 2 July 2015 between the Burma Army and Democratic Karen Buddhist Army (DKBA) on Asia Highway in Kaung Mhu Village, Kawkareik Township, Karen State, Burma/Myanmar led to the displacement of sixty-one households consisting of three hundred fifty-nine persons. The affected area was within a BPHWT field Area. Consequently, the BPHWT Field in-Charge and the BPHWT's Logistics Officer led a team there to deliver emergency rations and medicine.

Heavy rains caused historic flooding in Burma/Myanmar in late July 2015. The EART responded immediately, directly and through local partner organizations, with emergency rations, clothing, chlorine, personal hygiene items, protective sheeting, mosquito netting, water containers, medicine and other supplies top the hardest affected areas of Arakan and, Karen States as well as Ayeyarwaddy and Sagaing Regions.

On 6 October 2015, the Burma Army attacked the Shan State Progress Party (SSPP)/ Shan State Army – North (SSA-N) near Wanhai Village, Monghsu Township, Shan State after the latter refused to withdraw their soldiers from that area. Approximately 6,000 people were displaced by this fighting. These internally displaced persons (IDPs) stayed in Kyethi, Mongnawng, Mongsan, and Monghsu Villages with IDP camps established at Wansault and Hipar monasteries in Monghsu Township. The EART provided medicine and hygiene kits through its local partner, the Tai Youth Network.

Heavy rains triggered a landslide on 11 October 2015 in Mawchi Taung Paw Village, Hpa Saung Township in Karenni State. It was reported that 17 people died, 48 were badly injured, at least 30 people were still missing, and 4,000 were forced to leave their houses and land. In response, Sai Aung Min, a BPHWT health worker, led a relief team to the landslide area on 12 October 2015 and collaborated with youth CSOs to help the affected villagers. The landslide-affected people received tinned fish, cooking oil, rice, and blankets from the CSOs. The EART delivered emergency medicine and hygiene kits to the affected area.

13) Activities of Back Pack Health Worker Team

The BPHWT delivers three programs: Medical Care Program (MCP), Community Health Education and Prevention Program (CHEPP), and Maternal and Child Healthcare Program (MCHP). Integrated within and bridging across these three health programs are projects and activities for capacity building, health information systems and documentation, and monitoring and evaluation.

In 2015, the BPHWT provided healthcare in 20 field areas, through 100 BPHWT teams, to a target population of 244, 410 people. There were 37 stationary Back Pack teams during this year. There are currently 1,315 (women – 1,006 and men – 309) members of the BPHWT primary healthcare system living and working in Burma: 359 (women – 181 and men – 178) health workers, 741 (women – 675 and men –

66) Traditional Birth Attendants / Trained Traditional Birth Attendants (TBAs/TTBAs) and 215 (women – 150 and men – 65) village health volunteers/village health workers (VHVs/VHWs).

The following table provides an overview of the BPHWT field areas, the number of BPHWT health workers, VHV/VHWs, and TBA/TTBAs in each field area, the target populations, villages, households and a breakdown of the total cases treated in 2015.

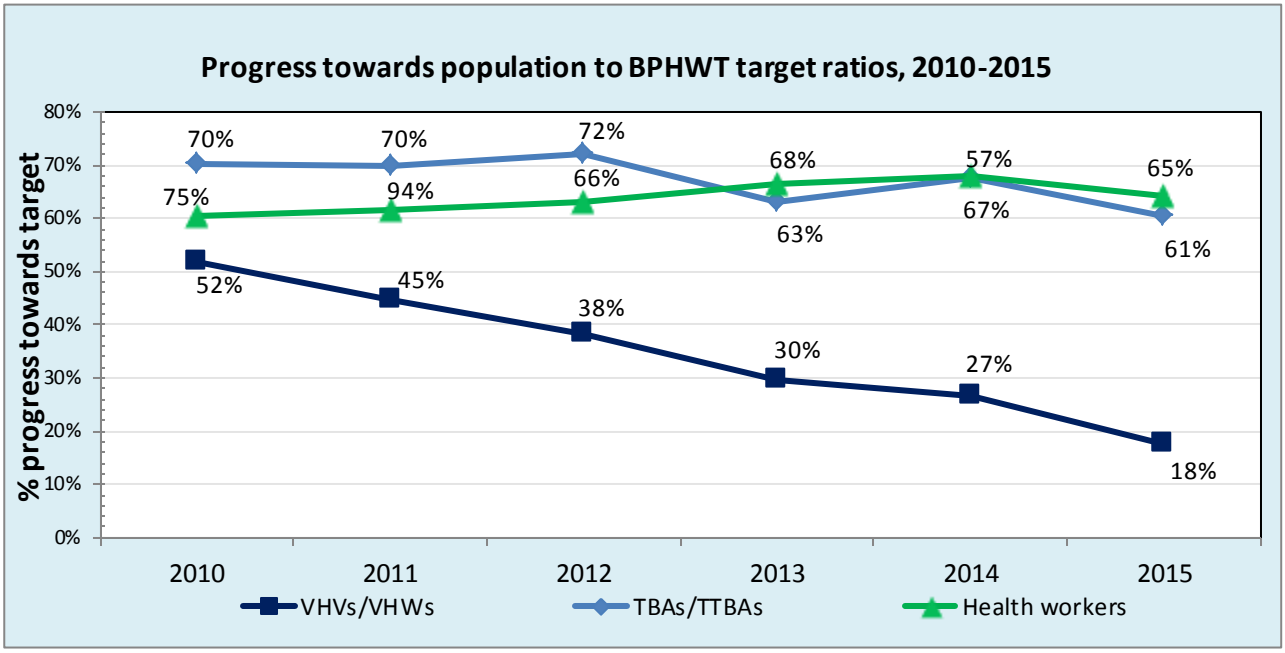
Table 2: Summary of the BPHWT Field Areas, HWs, VHV/VHWs, TBA/TTBAs, Target Populations and Cases Treated

No.	Areas	# of Teams	# of HWs	# of VHWs	# of VHVs	VHVs & VHWs	# of TBAs	# of TTBAs	TBAs &T TBAs	Villages	Households	Population	Caseloads
1	Kayah	7	24	0	12	12	27	18	45	50	3547	19820	5783
2	Kayan	5	18	0	8	8	13	22	35	46	1759	8957	6746
3	Special	3	10	0	0	0	11	0	11	16	1219	7626	2558
4	Taungoo	5	18	0	25	25	38	11	49	51	1993	11075	1783
5	Kler Lwee Htoo	7	24	29	23	52	32	15	47	48	1922	12419	3342
6	Thaton	7	24	0	17	17	50	25	75	37	3280	19316	6284
7	Papun	9	31	18	25	43	95	36	131	109	4969	30515	6382
8	Pa An	6	25	0	8	8	74	30	104	29	3276	18892	3792
9	Dooplaya	7	24	0	12	12	69	0	69	55	4326	22994	4706
10	Kawkareik	3	12	17	0	17	15	19	34	11	877	4758	1786
11	Win Yee	4	15	0	0	0	23	20	43	29	2098	12205	3382
12	Mergue/Tavoy	5	18	0	17	17	49	0	49	23	2070	11779	6707
13	Yee	6	22	0	0	0	21	0	21	19	2208	10309	5927
14	Moulamein	6	22	0	0	0	0	0	0	17	2507	12423	5089
15	Shan	6	21	0	0	0	10	0	10	52	2225	13520	6967
16	Palaung	3	11	0	0	0	18	0	18	14	621	3249	862
17	Kachin	4	15	0	4	4	0	0	0	15	848	5320	4627
18	Arakan	3	12	0	0	0	0	0	0	11	2863	8197	2867
19	Pa O	2	8	0	0	0	0	0	0	6	601	3801	1192
20	Naga	2	5	0	0	0	0	0	0	10	1210	7235	1478
Total		**100**	**359**	**64**	**151**	**215**	**545**	**196**	**741**	**648**	**44,419**	**244,410**	**82,260**

Table 3: Number of Health Workers, TBAs/TTBAs, VHVs/VHWs, and Target Population by Year

Year	# of HWs	# of TBAs/TTBAs	# of VHVs/VHWs	Target Population
2004	232	202	332	176,200
2005	287	260	625	162,060
2006	284	507	700	185,176
2007	288	591	341	160,063
2008	291	525	413	176,214
2009	289	630	388	187,274
2010	290	672	495	191,237
2011	318	722	462	206,620
2012	343	787	417	217,899
2013	379	711	333	224,796
2014	351	696	276	206,361
2015	359	741	215	244,410

TBA/TTBAs, VHV/VHWs, & Health Workers-to-Population Ratios as a % of Target Ratios over Time[1],[2]



13.1) Medical Care Program

The Back Pack Health Worker Team currently consists of 100 teams working among Internally Displaced Persons and vulnerable communities in Karen, Karenni, Mon, Arakan, Chin, Kachin, and Shan States, and the Pegu and Tenasserim Regions of Burma. Under the Medical Care Program (MCP), the BPHWT health workers address six health problems identified as contributing most significantly to morbidity and mortality in the target areas: malaria, diarrhea, acute respiratory-tract infection (ARI), anemia, worm infestation, and war trauma injuries. The most common disease in the BPHWT areas is malaria, followed by ARI, worm infestation, anemia, diarrhea, and dysentery.

Providing Health Care to communities

[1] While BPHWT began training TBAs in 2000, the MCHP only began systematically training TBAs in the BPHWT target areas in 2004. Therefore, only 2004-2010 TBA/population ratios are included. The BPHWT also began training VHVs in 2004.

[2] Targets are as follow: 1 BPHWT Health Worker: 400 people; 1 TBA: 200 people; 1 VHV: 200 people.

Table 4: Back Pack Health Worker Team Caseloads

No	Condition	Age				Total
		<5		>=5		
		M	F	M	F	
1	Anemia	314	340	1814	3550	6018
2	ARI(mild)	1882	1891	4668	5038	13479
3	ARI(severe)	942	997	1313	1503	4755
4	Beriberi	215	154	1526	2654	4549
5	Diarrhea	634	627	1301	1329	3891
6	Dysentery	275	347	978	1049	2649
7	Injury(gunshot)	0	0	14	15	29
8	Injury(landmine)	0	0	0	0	0
9	Injury Acute Other	163	161	908	563	1795
10	Injury(old)	43	46	503	294	886
11	Malaria (PF)	90	107	685	522	1404
12	Malaria (PV)	94	105	400	300	899
13	Measles	56	75	90	85	306
14	Meningitis	7	10	54	41	112
15	SuspectedAIDS	0	0	15	4	19
16	SuspectedTB	4	13	168	154	339
17	Worms	815	867	1572	1743	4997
18	Abortion	0	0	0	124	124
19	Post-Partum Hemorrhage	0	0	0	28	28
20	Sepsis	0	0	0	16	16
21	Respiratory Tract Infection (RTI)	0	0	13	161	174
22	Urenary Tract Infection (UTI)	35	50	970	1710	2765
23	Skin Infection	504	474	1058	1103	3139
24	Hepatitis	10	14	171	129	324
25	Typoid Fever	71	88	390	409	958
26	Arthritis	23	23	889	891	1826
27	Gastric Ulcer Deudinum Ulcer (GUDU)	30	56	2623	3039	5748
28	DentalProblem	165	188	928	992	2273
29	EyeProblem	193	219	754	849	2015
30	Hypertention	0	0	1698	2485	4183
31	Abscess	141	112	877	677	1807
32	Others	989	974	3784	5006	10753
Total		7695	7938	30164	36463	**82,260**
Grand Total		**15,633**		**66,627**		

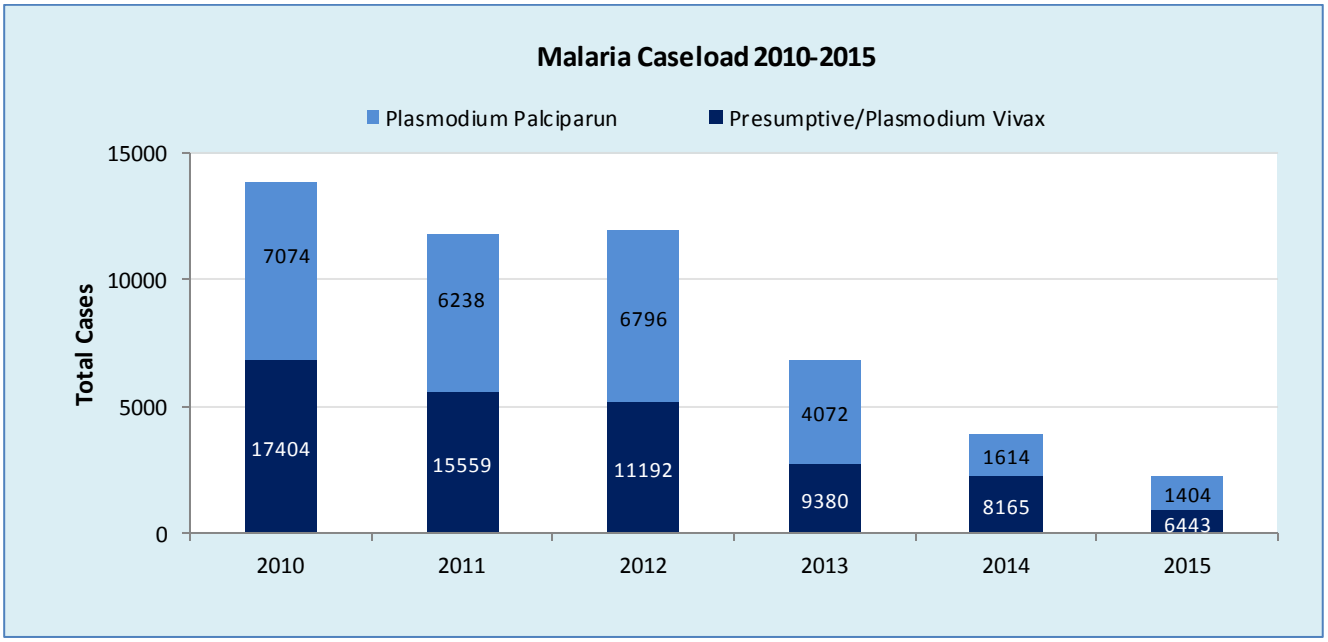
i. Malaria

The BPHWT has used Para-check, a rapid diagnosis test (RDT), to effectively confirm Plasmodium falciparum (*P.f.)* malaria diagnosis since 2007, and follows World Health Organization (WHO) guidelines to give Arteminisin-based Combination Therapy (ACT) treatment. The BPHWT aims to distribute insecticide-treated mosquito nets (ITNs) and engage in preventive health awareness-raising activities in order to decrease the prevalence of malaria. There were 27,600 ITNs distributed during 2015.

Providing Malaria Test

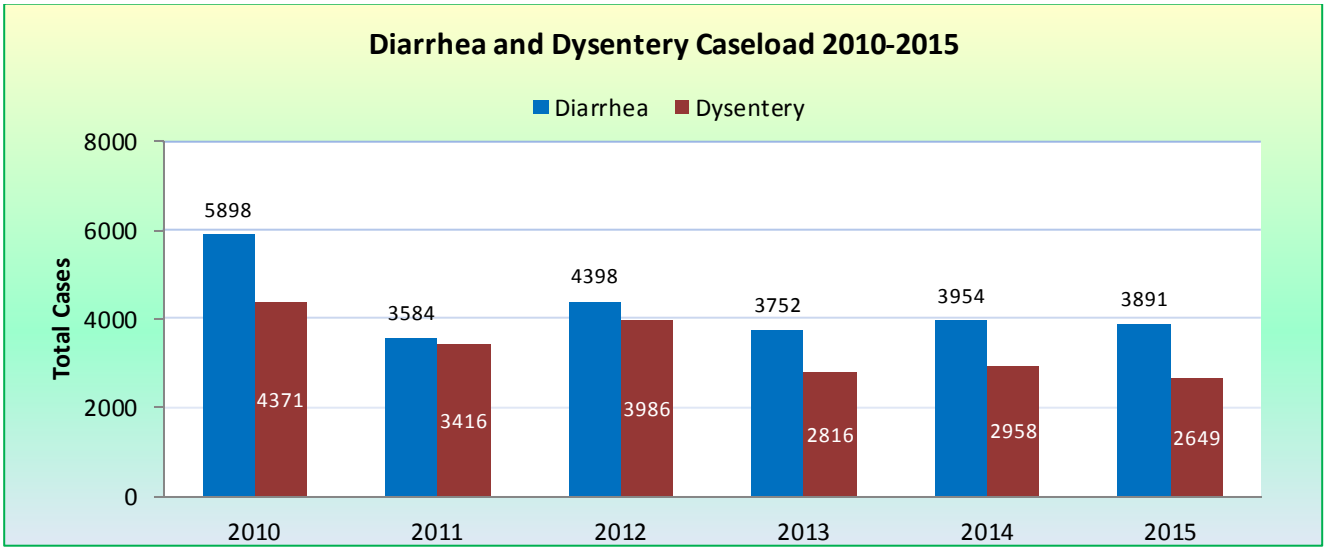
From 2003-2004, the BPHWT did not have small, portable diagnosis kits called Rapid Diagnosis Tests (RDT) to confirm cases of Plasmodium falciparum (*P.f.)* malaria. RDT usage began in 2005, but there were not enough RDTs available to cover all field areas; but by 2008 and 2009, there were enough RDTs to distribute to all field areas. Thus, the Back Pack Health Worker Team updated its protocol for treating malaria to test all patients who have a fever with a Para-check RDT, and if the results are positive then P.f. malaria treatment must be provided using ACT treatment, which is in-line with the Burma Border Guidelines (BBG) protocol.

Since the early of 2014, the BPHWT has used the SD Bioline which can test for both P.f and P.v malaria. During 2015, there were 2,303 malaria cases treated by the field health workers. According to the graph showing below, malaria has sharply decreased. In addition, "The Long Road to Recovery" survey report also showed that the prevalence rate for P. falciparum malaria decreased dramatically from 7.3% in 2008 to 2.3% in 2013. However, there are still malaria cases that the field health workers will have to continue providing treatment.



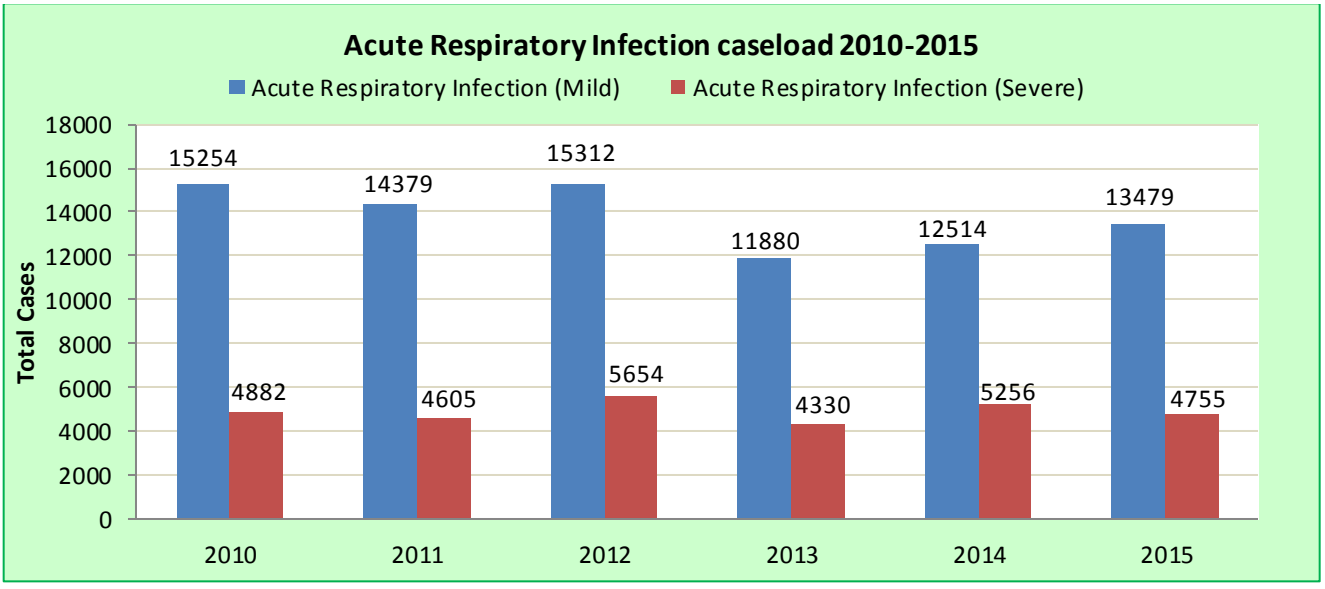
ii. Diarrhea and Dysentery

In general, diarrhea and dysentery cases still steadily from those recorded since 2013 to 2015 year. Although, the BPHWT activities have had a clear impact in the healthy behavior of communities, diarrhea and dysentery were still high in the communities due to the complex operating environment, and wider social determinants of health (eg food security).



iii. Acute Respiratory Infection (Mild)/(Severe)

The annual cases of acute respiratory infection was 18, 234 – 13, 479 mild and 4,755 severe. The totals of 4,427 were under five children. It seems slightly more comparing to the previous year. However, it cannot be interpreted that there was more ARI case during this year because it depends on the process of the medicine for this case. This graph can only indicate the numbers ARI cases treated by the field health workers by yearly.



iv. Worm Infestation

The BPHWT established a de-worming program in 2003 in order to reduce malnutrition among children. As part of the Community Health Education and Prevention Program, the BPHWT also provides health education, focusing on hygiene, clean water, and sanitation activities among the villages. Because of the wide distribution of the BPHWT's de-worming program in all the BPHWT target areas, cases for worm infestation decreased rapidly from year to year. There were 4,997 worm infestation cases treated in 2015.

v. Suspected Pulmonary Tuberculosis and AIDS Cases

The total number of suspected cases of tuberculosis (TB) was 339 cases – comprised of 159 women and 180 men, only eight cases were under five that recorded by the health workers. The highest figure founded in Kayan areas which was 147 cases and follow by Mergue/Tavoy – 53 cases. Health workers could not treat the suspected TB patients because the BPHWT is not equipped to oversee a TB treatment program in the target areas, and the health workers are not prepared to manage a TB program or TB patients. TB patients need long-term treatment and should receive appropriate care and oversight. The Back Pack Health Worker Team is not able to provide this level of sustained care since its activities are in target areas that are unstable. The BPHWT is only able to provide health education and advise patients where to access appropriate treatment and care. In the early of 2014, the BPHWT coordinates with Mae Tao clinic to refer TB positive patients to Shoklo Malaria Research Unit (SMRU). TB is considered one of the main health problems experienced by internally displaced persons.

There were also 19 suspected AIDS cases – comprised of 15 women and 4 men in Kayan, Pa An, Mergue/Tavoy, Yee, Palaung, Naga and Kachin areas. There were the most suspected AIDS cases – 7 cases recorded by health workers from Kachin area and no under five cases recoded.

vi. Acute Landmine and Gunshot Injuries

In 2015, there was no landmine cases recorded by the health workers, but there were still 29 gunshot cases treated. 14 cases were men and 15 cases were women. There was no under-five case. However, some cases in the field areas were not recorded because the field health workers recorded the cases that they evidenced.

Table 5: Gunshot cases

No.	Area	Gunshot Cases		
		>=5 ages		
		M	F	Total
1	Special	9	0	9
2	Taungoo	1	0	1
3	Thaton	2	0	2
4	Pa An	2	0	2
5	Kawkareik	3	0	3
6	Mergue/Tavoy	0	1	1
7	Shan	0	8	8
8	Pa O	1	0	1
9	Palaung	2	0	2
	Total	**20**	**9**	**29**

vii. Patient referral

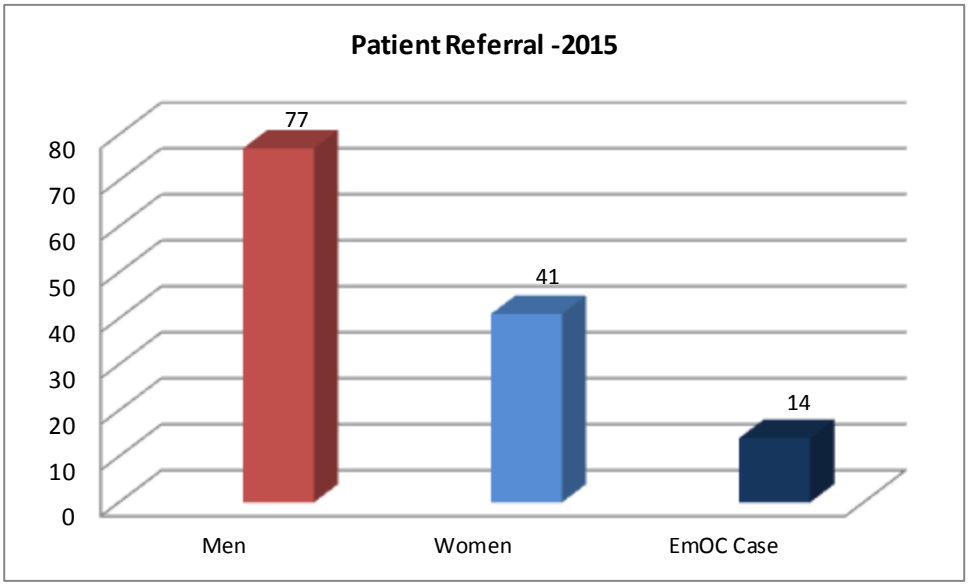
Referral Sites:

- Taungoo Hospital
- Than Daw Public Hospital
- Yan Gon Hospital
- Kyaut Kyi Hospital
- Ta Eu Wah Plaw Clinic
- Pa An Hospital

- Kawkareik Hospital
- Tha Phu S' Yah hospital
- Musel Hospital
- Num Ma Tu Hospital
- Hla Show Hospital

Table 6: Referral cases

Referral cases:		
• 13 Hernia and Hydrocele • 9 Suspected TB • 6 Motorbike Accident • 6 Acute Watery diarrhea with Severe dehydration • 6 Obstetric labor • 6 Cornea Scar • 5 Suspected Cancer • 5 Hypertension • 4 Meningitis • 4 Abortion • 4 Very sever Pneumonia • 4 Acute Incident Injury • 4 Gastritis (PU) • 4 Appendicitis • 2 Abscess	• 3 Acute Injury • 3 Chronic Asthma • 3 Chronic Asthma • 3 Gall bladder stone • 3 Dog Bite • 3 Prolong Labour • 3 Placenta Retailed /PPH • 3 Rheumatic Fever • 3 Acute Injury Gunshot • 3 Prostate Gland • 2Tumour • 2 Influza • 2 Bear bites • 2 Eclampsia • 1 Chronic Arthitis	• 1 Ante partum hemorrhage • 1 Suspend HIV • 1 Hypoglycemia • 1 Fetal Death in Uterus • 1 G6PD deficiency • 1 Acute eye injury • 1 stroke • 1 Anemia • 1 Suicide • 1 GI Bleeding • 1 Snake bite • 1 GI Bleeding • 1 Hepatitis and • 1Urinary stone



13.2) Community Health Education and Prevention Program

The Community Health Education and Prevention Program (CHEPP) aims to empower the internally displaced persons and vulnerable populations of Burma with skills and knowledge related to basic healthcare and primary healthcare concepts. CHEPP focuses on the improvement of hygiene, water and sanitation systems, nutrition, and other health promotion-related issues. The main health issues addressed under the Community Health Education and Prevention Program are:

- Malaria prevention
- Hygiene and sanitation
- Diarrhea prevention
- Malnutrition
- High-risk pregnancy
- Breast feeding practices
- HIV/AIDS education
- Prevention and awareness of communicable diseases

The Community Health Education and Prevention Program is also integrated into school health programs and village health workshops. In terms of preventative activity, the BPHWT field workers distribute Vitamin A and de-worming tablets. They also provide latrines to schools and communities.

13.2.1 School Health Sub-Program:

In 2015, the BPHWT implemented its school health program in 339 schools with 1,575 teachers: 1,246 women and 329 men. There were 30,691 students - comprised of 14,831 boys and 15,860 girls receiving health education from BPHWT's health workers. The program also distributes de-worming medicine and Vitamin A, personal hygiene supplies, and materials for the construction of latrines. However, due to the funds shortage; there was no personal hygiene supplies distributed and no school latrine was installed.

13.2.2 Nutritional Sub-Program:

Under the Nutritional Sub-Program of the CHEPP, the BPHWT distributes de-worming medicine to children from the age of one to twelve year old and Vitamin A to the children from the age of six month to twelve year old. This is essential to preventing malnutrition. During 2015, 14,402 children received De-worming medicine (Albandozole) and 41,282 children received Vitamin A. The BPHWT did stop providing Vitamin A supplementation to prenatal and postpartum women according to the WHO recommendations since the beginning of 2013. In addition, BPHWT field health workers also provide health education regarding on this topic in village health workshop in every six month to improve the health knowledge of the communities.

Distributing Vitamin A and De-worming medicines to school children

Table 7: Number of Children Receiving Vitamin A									
No	Area	CHILDREN'S AGES						Total	
		6-<12 months		1-<6 years		6-12 years			
		M	F	M	F	M	F	M	F
1	Kayah	304	287	414	410	661	644	1378	1341
2	Kayan	161	156	294	300	593	608	1047	1063
3	Special	161	152	202	197	409	393	772	741
4	Taungoo	203	229	408	390	698	723	1309	1342
5	Kler Lwee Htoo	251	266	477	514	843	810	1570	1590
6	Thaton	407	434	445	459	856	891	1707	1784
7	Papun	392	425	1016	975	1629	1619	3036	3019
8	Pa An	235	260	602	622	1152	1184	1989	2065
9	Dooplaya	201	186	304	279	597	545	1101	1010
10	Kawkareik	125	130	149	137	250	243	523	510
11	Win Yee	90	119	331	358	421	477	841	953
12	Mergue/Tavoy	161	164	205	219	414	419	779	801
13	Yee	92	118	320	415	604	696	1016	1228
14	Moulamein	367	436	554	647	1055	1183	1976	2265
15	Shan	87	77	191	238	174	188	451	503
16	Palaung	95	108	187	203	210	231	492	541
17	Arakan	43	54	98	96	123	134	264	284
Total		**3,375**	**3,601**	**6,197**	**6,459**	**10,689**	**10,988**	**20,251**	**21,,040**
		6965		**12,651**		**21,667**		**41,282**	

Table 8: Number of Children Receiving De-worming Medicine				
No	Area Name	Ages (**1 – 12 Years**)		Total
		M	F	
1	Kayah	495	472	967
2	Kayan	332	364	696
3	Special	107	91	198
4	Taungoo	646	583	1229
5	Kler Lwee Htoo	613	560	1173
6	Thaton	313	328	641
7	Papun	896	1027	1923
8	Pa An	508	582	1090
9	Dooplaya	92	80	172
10	Kawkareik	113	107	220
11	Win Yee	415	478	893
12	Mergue/Tavoy	181	169	350
13	Yee	569	628	1197
14	Moulamein	637	758	1395
15	Shan	468	627	1095
16	Palaung	287	333	620
17	Arakan	263	280	543
Total		**6,935**	**7,467**	**14,402**

13.2.3 Water and Sanitation Sub-Program:

The BPHWT aims to provide one gravity flow for 60 household and 300 population; one shallow well for 10 households and 50 population, and one community latrine for every 5 to 10 people in all its target areas. The Back Pack Health Worker Team has established water and sanitation projects since 2005. During 2015, the BPHWT teams built 18 gravity flow water systems and the beneficiary population that has received gravity flow water system includes 1,948 households composed of 11,058 people. The BPHWT also built 9 shallow well water systems which have been received by 235 households and 1,136 beneficiaries. The BPHWT also provided 817 community latrines to 5,529 populations.

Building Latrine and installing gravity flow water system in villages

Table 9: Water and sanitation

No	Field Area	Gravity Flow				Shallow Wells				Community Latrines			
		No.	HH	Pop.		No.	HH	Pop.		No.	HH	Pop.	
				M	F			M	F			M	F
1	Kayah	1	52	196	200	0	0	0	0	175	175	368	374
2	Kayann	2	60	152	171	4	113	266	265	162	162	424	452
3	Special	2	256	770	1056	0	0	0	0	50	96	242	322
4	Kler Lwee Htoo	1	120	342	343	0	0	0	0	0	0	0	0
5	Thaton	1	209	761	922	0	0	0	0	50	209	761	922
6	Papun	3	168	480	426	2	38	67	89	60	60	67	89
7	Pa An	4	341	1170	1118	0	0	0	0	0	0	0	0
8	Dooplaya	2	529	980	1070	0	0	0	0	0	0	0	0
9	Win Yee	1	93	196	197	2	63	166	178	0	0	0	0
10	Yee	0	0	0	0	1	21	40	65	200	200	477	523
11	Pa O	1	120	236	272	0	0	0	0	120	120	236	272
Total		**18**	**1948**	**5283**	**5775**	**9**	**235**	**539**	**597**	**817**	**1022**	**2575**	**2954**
				11,058				**1,136**				**5,529**	

13.2.4 Village Health Workshop

The BPHWT organizes village health workshops every six months. These workshops cover topics such as water, sanitation, and disease prevention. Village health workshops typically focused on discussions of water-borne diseases. Strategies for preventing the spread of infection of malaria, diarrhea, respiratory infections, worm infestations, measles and typhoid are also addressed. Other topics discussed included malnutrition, waste disposal, Vitamin A, de-worming medicine, high-risk pregnancies, and how to make oral rehydration solution (ORS). The occurrence of workshops depended on the security situation in the community and the available time. Workshops usually involved small group discussions with the topics from these discussion groups then brought back to the main group for general discussion.

During 2015, the BPHWT organized 97 village health workshops in 14 targeted field areas, attended by 6,813 people – 3,034 men and 3,779 women. Communities were invited to send representatives from different sectors such as religious leaders, authorizes, villagers, women organization, youth organization, health workers, TBAs/TTBAs, VHVs/VHWs, shop keepers and school teachers to attend discussions. These representatives then go back to their respective communities and further transmit their knowledge about these health practices. The focus of the sessions is on primary healthcare concepts, such as prioritizing preventing the spread of infection as opposed to the curative treatments that villagers currently rely upon. These sessions also include a discussion period in which community members can raise further issues affecting their health. During these sessions, the health priorities of the community are identified and the community members participate in discussions about how the BPHWT can help to address these issues.

Organizing Village Health Workshop

Table 10: Village Health Workshop

NO.	Areas	# VH workshop	Participants		Total
			M	F	
1	Special	7	274	336	610
2	Taungoo	1	14	13	27
3	Kler Lwee Htoo	10	500	631	1131
4	Thaton	7	122	181	303
5	Papun	3	72	47	119
6	Pa An	12	206	373	579
7	Kawkareik	10	422	414	836
8	Win Yee	8	175	216	391
9	Mergue/Tavoy	10	319	357	676
10	Yee	13	422	586	1008
11	Moulmein	12	404	484	888
12	Pa O	1	8	13	21
13	Palaung	2	41	51	92
14	Kachin	1	55	77	132
	Total	**97**	**3,034**	**3,779**	**6,813**

13.2.5 Village Health Committee

During the second six month period of 2015, the BPHWT started to establish Village Health Committee (VHC) in Win Yee, Kawkareik, and Pa An. There were eight VHC established - 3 VHCs in Pa An, 3 VHCs in Kawkareik, and 2 VHCs in Win Yee. There were 74 participants, comprised of 30 women and 44 men. The purpose of establishing VHC is to improve community participation and to sustain development of a primary healthcare. The target goal was to have at least 30% participation from women in the VHCs. The VHCs surpassed that goal with 41% of VHC members being women. Each VHC targets to have 7-9 members. These representatives are from village administration committee, local health workers, teachers, religious leaders, women and youth groups.

The VHCs are responsible for patient referral, community empowerment and participation, providing health education and environment cleaning, over sight of clinic management, and coordination with other CBOs and NGOs activities. These VHCs organize quarterly regional meeting among themselves in their villages.

13.3) Maternal and Child Healthcare Program:

The Back Pack Health Worker Team began the Maternal and Child Healthcare Program (MCHP) in 2000. The BPHWT has trained Traditional Birth Attendants (TBAs) every year in order to reach their goal of ten TBAs for every 2,000 people. Since 2012, the BPHWT has started to train Trained Traditional Birth Attendants (TTBAs) with higher skills to provide safe deliveries in order to reduce maternal and child deaths.

During 2015, 3,042 pregnant women received de-worming medicine (Mebendozole) and 3,226 women and pregnant women received iron supplements. In addition, 675 TBAs/TTBAs were working with the Back Pack Health Worker Team. They assisted in 3,341 births; of these, 3,328 were live births, 12 were stillbirths or abortions, and there were 19 cases of neo-natal deaths. The TBAs/TTBAs also recorded 3 maternal deaths. There were 14 obstetric cases referred during 2015.

Providing Postnatal Care to a mother

13.3.1) Trained Traditional Birth Attendant (TTBA) Training: In 2010-2011, an external evaluation facilitated by Burma Relief Center (BRC) recommended that TBAs in the targeted villages must have more knowledge and skills in order to be more effective. Therefore, since 2012, the BPHWT has decided to train TBAs to become TTBAs who will have greater knowledge and skills to provide safe deliveries, related health education, and an effective referral system. It is twenty-day training. The trainers are MCHP supervisor who have done TTBA ToT. During 2015, there were four TTBA trainings conducted in the three field areas at the table below.

Table 11: TTBA training

NO	Area	# TTBA Training	Participants		
			Men	Women	Total
1	Win Yee	1	0	20	**20**
2	Pa An	2	1	29	**30**
3	Kawkareik	1	0	14	**14**
Total		**4**	**1**	**63**	**64**

13.3.2) Traditional Birth Attendant/Trained Traditional Birth Attendant Workshops: The BPHWT organizes TBA/TTBA workshops every six months in order to improve and upgrade TBAs/TTBAs' knowledge and skills, and to enable them to share their experiences and participate in ongoing learning opportunities. Delivery kit and maternity kit supplies were also restocked. These workshops provided a supportive environment for the discussion of issues faced in the field, which were then documented and reported at the reproductive health workshop and the BPHWT Six-Monthly General Meeting.

In 2015, 104 TBA/TTBA follow-up workshops were organized in 20 field areas which included 555 TBAs/TTBAs, comprised of 57 men and 498 women. However, some TBAs/TTBAs, who currently work with the BPHWT, could not participate in the workshop because of time limitations and workshop locations. During the workshops, 1,200 TBA/TTBA kits and 4,200 maternity kits were distributed in order to restock in field areas.

13.3.3 Maternal and Child Healthcare refresher workshop

During this period, the BPHWT organized a maternal and child healthcare refresher workshop at Mae Sot office. This workshop was organized from 14th July to 1st August 2015. There were 30 MCH supervisors and workers, comprised of 5 men and 25 women who attended this workshop. The facilitators were the MCH coordinator and staff from BPHWT and MTC. The discussion topics are:

- Introduction of SDC Project
- MCH Supervisor report presentation

- ANC & Normal Pregnancy
- Bleeding in Early & late pregnancy
- Normal Labor & Delivery
- PPH Prevention and Treatment
- New born care/PNC
- Review of MCH forms
- Future plans

13.3.4 Trained Traditional Birth Attendant Training of Trainers

The BPHWT has been conducting TTBA training since 2012 to provide greater knowledge and skills to provide safe deliveries, related health education, and an effective referral system. TTBAs are trained by the MCH supervisors. Therefore, the MCH supervisors need this ToT skill to provide the trainings in the field areas. As a result, the MCH coordinator conducted three days TTBA ToT on 12 to 14 September 2015. There were 25 MCH supervisors, comprised of 7 men who attended this ToT.

Table 12: Progress toward TBA to Pregnant Women Target Ratio 2004-2015

Year	TBAs/TTBAs	Pregnant	TBAs/TTBAs/Pregnant Ratio	Target TBA/Pregnant Ratio	% Progress to TBA/Pregnant Target
2004	202	7,453	37	8	22%
2005	260	6,855	26	8	30%
2006	507	7,833	15	8	52%
2007	591	6,771	11	8	70%
2008	525	7,454	14	8	56%
2009	630	7,922	13	8	64%
2010	672	8,089	12	8	66%
2011	722	8,740	12	8	66%
2012	787	9,217	12	8	68%
2013	711	9,509	13	8	60%
2014	696	8,729	13	8	64%
2015	741	10,339	14	8	57%

Traditional Birth Attendant-to-Pregnant Ratio as a % of the Target Ratio in BPHWT Target Areas over Time

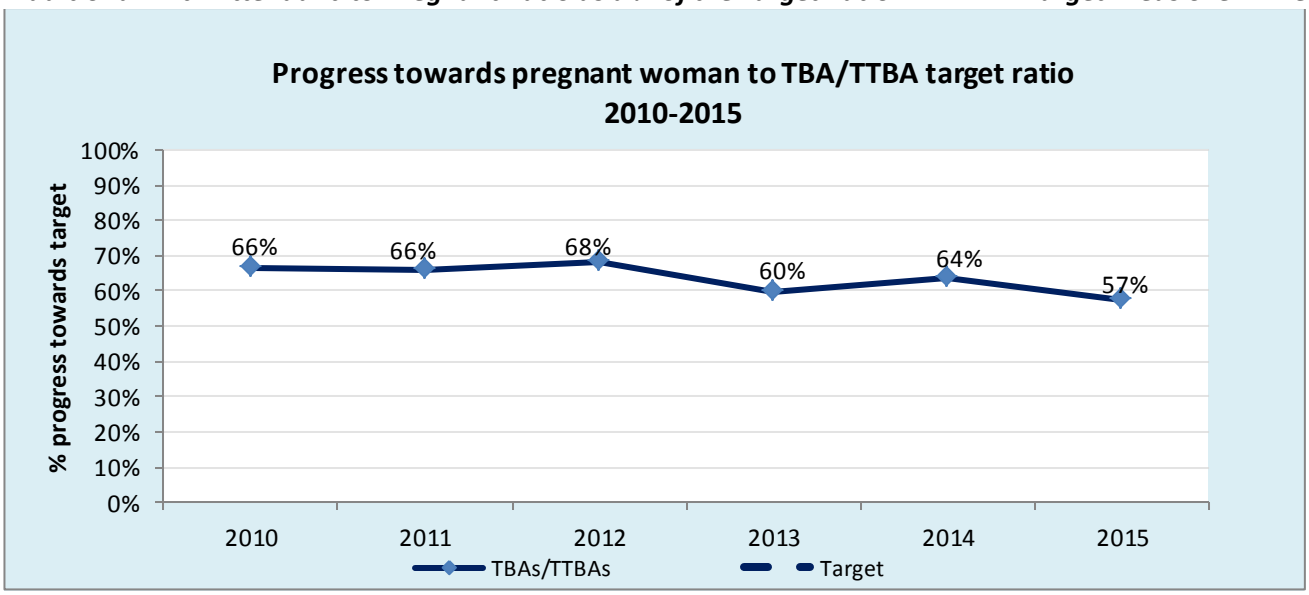


Table 13: Birth and Death Records – 2015

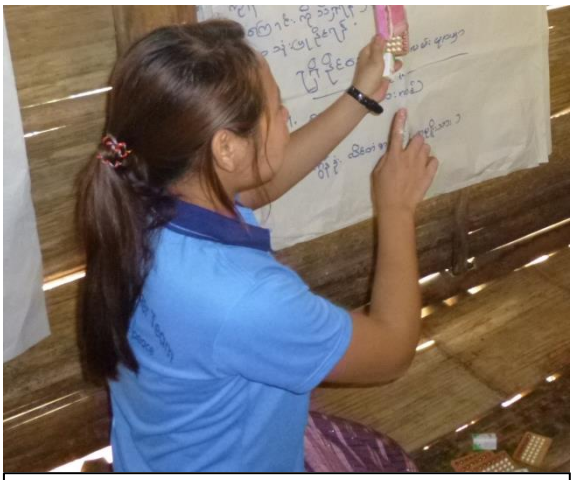
No	Area	Deliveries	Live Births	Still Births/ Abortions	Deaths		<2.5 Kg	=>2.5 kg
					Neonatal	Maternal		
1	Kayah	104	104	0	0	0	0	104
2	Kayan	150	149	1	0	0	3	134
3	Taungoo	146	146	0	6	0	0	0
4	Klew Lwee Htoo	121	120	1	0	0	3	80
5	Thaton	381	378	3	1	0	37	334
6	Papun	532	530	2	5	2	38	425
7	Pa An	381	381	0	2	0	17	327
8	Dooplaya	372	371	1	2	0	41	330
9	Kawkareik	54	54	0	1	0	6	41
10	Win Yee	198	195	3	1	1	15	171
11	Mergue /Tavoy	138	138	0	0	0	3	96
12	Yee	152	152	0	0	0	0	152
13	Shan	32	32	0	0	0	0	32
14	Palaung	124	123	1	0	0	1	107
15	Kachin	0	0	0	0	0	0	0
16	Chin	250	250	0	0	0	3	247
17	Arakan	84	84	0	1	0	1	83
18	Special	15	15	0	0	0	0	15
19	KBC	107	107	0	0	0	0	107
		3,341	3,329	12	19	3	168	2,785

Table 14: Pre and Post Natal Distribution of De-worming, Ferrous Sulphate, and Folic Acid - 2015

No	Area	De-Worming	F/S & F/A
1	Kayah	90	104
2	Kayan	88	138
3	Taungoo	146	146
4	Kler Lwee Htoo	118	121
5	Thaton	356	374
6	Papun	394	481
7	Pa An	378	378
8	Dooplaya	335	335
9	Kawkareik	54	54
10	Win Yee	199	199
11	Mergue/Tavoy	138	138
12	Yee	152	152
13	Shan	32	32
14	Palaung	124	124
15	Kachin	0	0
16	Chin	250	250
17	Arakan	66	78
18	Special Pa An	15	15
19	KBC	107	107
	Total	**3,042**	**3,226**

13.3.5 Family Planning Activities

The BPHWT introduced family planning activities in 2003 in order to improve maternal and child health status among internally displaced persons. The BPHWT provides family planning education and supplies to those communities who would like to access these services. The aim of the BPHWT family planning activities is to address urgent health concerns among the displaced communities. The BPHWT distributes and promotes the use of three family planning methods, namely the contraceptive pill, Depo-Provera, and condoms.



A health worker is explaining family methods

In 2015, the BPHWT provided family planning services to 4,926 people, of whom 207 were men. This statistic reflects that only a small number of men participate in family planning. This is due to some barriers of tradition belief. To improve the knowledge of family planning, BPHWT has included the family planning education session in the VHW's curriculum since 2012.

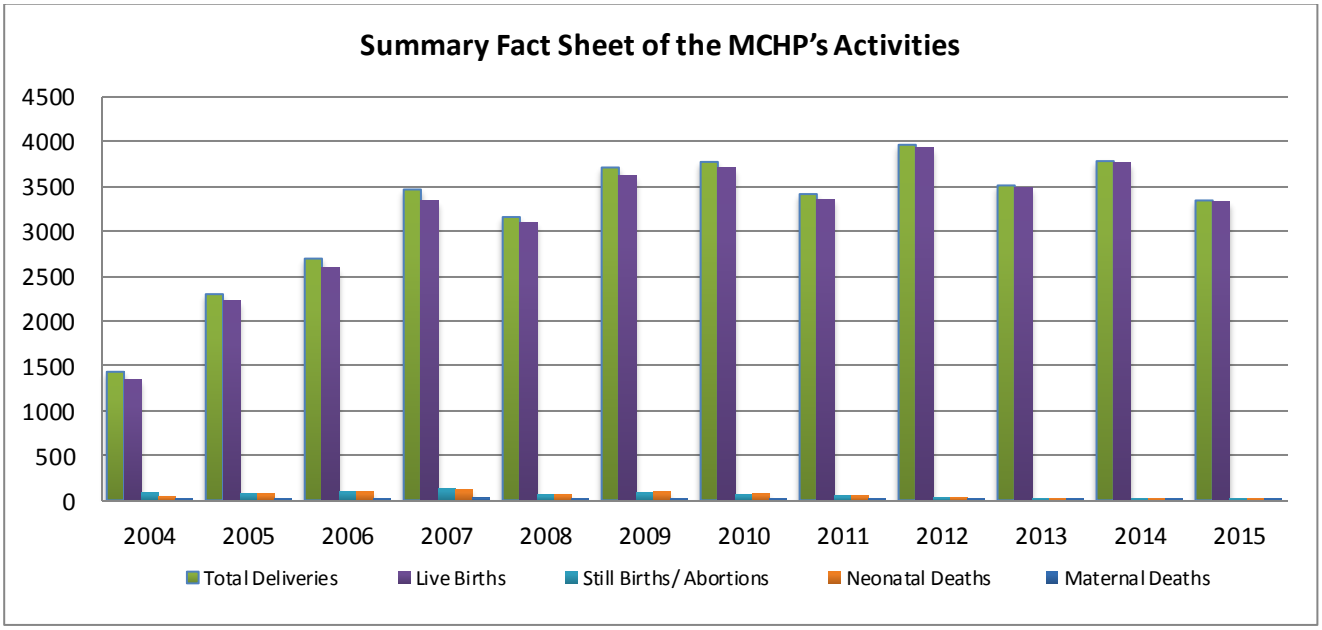
Table 15: Family Planning Activities – 2015

No	Area	Total Clients	Age		Visits		Clients			Quantity		
			< 19	> = 19	New	Follow/ Up	Depo	Pill	Condon	Depo (Inj)	Pill (Pack)	Condon (Pieces)
1	Kayah	272	9	263	91	181	172	89	11	344	534	165
2	Kayan	270	15	255	115	155	143	97	30	188	582	1089
3	Taungoo	137	0	137	62	75	80	42	15	160	248	348
4	Klew Lwee Htoo	77	1	76	23	54	58	18	1	116	108	45
5	Thaton	749	29	720	140	609	475	249	25	1041	1056	1209
6	Papun	396	1	395	30	366	131	255	10	162	1490	396
7	Pa An	485	9	476	113	372	244	222	19	407	994	501
8	Dooplaya	309	30	279	90	219	169	99	41	325	648	1349
9	Kawkareik	201	10	191	45	156	83	118	0	165	607	0
10	Win Yee	142	1	141	23	119	32	82	28	61	457	1440
11	Mergue/Tavoy	179	0	179	66	113	119	56	4	248	332	576
12	Yee	578	76	502	71	507	484	84	10	604	290	300
13	Shan	73	4	69	47	26	68	4	1	119	16	18
14	Palaung	509	6	503	146	363	500	9	0	958	39	0
15	Kachin	0	0	0	0	0	0	0	0	0	0	0
16	Chin	30	0	30	30	0	28	0	2	50	0	30
17	Arakan	164	29	135	70	94	67	87	10	132	528	440
18	KBC	355	0	355	36	319	292	63	0	580	376	0
19	Special	0	0	0	0	0	0	0	0	0	0	0
Total		**4,926**	**220**	**4706**	**1198**	**3728**	**3145**	**1574**	**207**	**5660**	**8305**	**7906**

13.3.6 Summary Fact Sheet of the MCHP's Activities

Years	2011	2012	2013	2014	2015
1. Total Deliveries	3412	3961	3,508	3,779	3,341
2. Live Births	3356	3927	3,486	3,760	3,329
3. Still Births/ Abortions	50	35	24	19	12
4. Neonatal Deaths	53	37	14	18	19
5. Maternal Deaths	13	9	7	2	3
6. Low Birth Weight	254	263	103	212	168

In 2015, there were three maternal deaths out of 3,341 total deliveries and the main causes of maternal deaths were PPH and Obstructive labour. Neonatal mortality rates during deliveries, attended by the BPHWT, have slightly increased in comparison with the previous year. However, the BPHWT is still trying to provide higher skills and knowledge of TBAs such as providing TTBA trainings to i ncrease safe delivery, including health education, referral system. Additionally, the BPHWT conducts TBA/TTBA workshops to update those TBA skills and knowledge that will increase the implementation of safe birthing practices and improve maternal and child health in every six months.



TBA/TTBA and Maternity Kit Distributed:

Maternity Kit Contents:	TBA/TTBA Kit Contents:	
• Providone	• Syringe ball	• Compress
• Cotton	• Non-sterilized gloves	• Multicolor bag for kit (smallest size)
• Vitamin A	• Sterilized gloves	• Plastic sheet
• Albendazole	• Plastic bags for medicine	• Package of plastic bags for kit
• Folic C	• Providone	• Towels
	• Terramycin eye ointment	• Nail clippers
	• Thread	• Scissors
	• Ink	

13.3.7 Reproductive Health Awareness

During the second six month period of 2015, the MCHP supervisors started conducting RH awareness workshop in three field area – Pa An, Win Yee, and Kawkareik, comprised of thirteen back pack teams. Each workshop takes about three hours. The key topics discussed in this worksh op are ANC, PNC, abortion, high risk pregnancy, danger signs in pregnancy, referral, family planning, breast feeding, nutrition, and anemia. This RH workshop is conducted quarterly in the communities. There were 631 participants, comprised of 452 women and 179 men and 84 were under 15 age groups. The BPHWT plans to continue this RH awareness to improve the knowledge and awareness of reproductive ages.

Testimonials from the Field

"Overcoming Many Challenges"

I am a Back Pack health worker in the Win Yee Field Area. Recently, I traveled to a local village to give health education and TBA training. At the TBA training, there was a 47 year old TTBA who felt that she knew everything, disagreed with many topics which I taught, and had a generally negative attitude. She commented, "I am an expert about the methods of delivering babies more so than the other TTBA workers".

Somewhat later, this TTBA made a delivery which took over 30 minutes. Then the mother began to postpartum hemorrhage: she could not feel anything when her feet and hands were touched. The TTBA referred the woman to me for help.

When I arrived, the woman was unconscious and bleeding. My assistant and I gave essential emergency treatment and looked after her overnight. Then, thank God, the woman survived. All of us - the TTBA, woman's family, and I - then started to smile and became filled with happiness. I became a hero to the local people and showed the truth of my previous teaching to the TTBA, correcting her misunderstandings and prejudgments. This was the happiest time ever during my work experience because I saved a life, gained the trust of the local community, and convinced the TTBA that my teachings about safe deliveries worked in practice.

"Happiness and sad smile"

Is it not our everyday normal duty to take care of patients? When doing these duties, some days are good and some not so good. This is one day of mine which was not so good, but also good.

On that day, a man rushed to me saying that his wife was ready for delivery, but was facing many difficulties to give birth. Even though I have experience in deliveries; I still cannot control my feelings when I see a woman facing difficulties in giving birth. Adding to my emotions at the time, there was no one to take care of my two little children who were with me; so I had to take them with me to the patient's house. Despite these worries, I tried to be calm and control my feelings because the woman needed me.

When I reached the patient, I worried a lot about her situation and only focused my attention on her and her situation, forgetting about my children. The woman faced an abnormal delivery because the head of the child was stubbed. According to our health worker rules and regulations, we should not provide any delivery alone if we have this type of case. However, there was no choice because the woman was in an emergency situation. Therefore, I had to try to do my best to safely delivery the baby and protect the mother.

With the TBA telling me to hurry up, I immediately took the medical supplies needed for the abnormal delivery and worked to make the delivery. Sweat was poring down from my face as I did the necessary procedures to deliver the baby. As much as I tried, sadly I could not save the baby's life. But I was able to save the mother's life.

Even though I could not save both lives, both the TBA and the woman's family gave me so many thanks for saving the mother's life and trying so hard to safely deliver her baby. As I left the patient's house with my two children, a smile formed on my face. While I felt sad about the loss of the woman's baby, I was also feeling very happy since I was able to save the mother's life and saw that the community really trusted and needed me. So this was a not so good day, but also a very good day in my duties to take care of patients in my community….

Naw Aye Aye Pwint, MCH Supervisor, Win Yee BPHWT Field Area

13.3.7 Nutrition for Pregnant Women

Maternal nutrition is a great concern in the areas that BP teams serve. MCH workers often provide information about nutrition for pregnant women, however; pregnant women cannot afford the necessary nutrition for a healthy pregnancy. According to The Long Road to Recovery, 11.3% of women of reproductive age were moderately/severely malnourished in 2013. Malnutrition during pregnancy is linked to poor birth outcomes such as intrauterine growth retardation and low birth weight infants.

Therefore, during the second six month period of 2015, the MCH program has started nutrition project for pregnant women in three field areas – Pa An, Kawkareik, and Win Yee and 11 BP teams in those areas. The MCH workers provide oil, yellow bean, eggs, canned fish, dried fish, iodized salt, and sugar. There were 414 pregnant women received nutrition foods during this period. Because of the nutrition program, it is easier for pregnant women to participate in Back Pack's ANC program.

14) Field Meetings and Workshops

The BPHWT conducts field meetings and field workshops twice a year in the targeted field areas. In 2015, there were 35 field workshops and 29 field meetings conducted in the targeted field areas; there were 306 (183 men, 123 women) participants who attended field meetings and 344 (166 men, 178 women) participants who attended field workshops.

Table 16: Field Workshops and Meetings – 2015

Description	# of Workshops/Meetings	Men	Women	Total
Field Workshops	35	166	178	344
Field Meetings	29	183	123	306

The objectives of the field meetings are to meet with local community leaders to:

- Discuss the current healthcare situation and concerns in the community
- Review the various BPHWT programs – Medical Care Program, Community Health Education and Prevention Program, and Maternal and Child Healthcare Program
- Identify the healthcare and health education needs of the community and related issues; assign priorities according to these needs, and identify those needs that can be addressed by the BPHWT
- Collaborate to develop a plan for the BPHWT to meet the identified healthcare and health education needs of the community
- Obtain the approval, support, and active participation of community leaders in implementing the community healthcare and health education plan

The objectives of the field workshops are to:

- Improve the skill sets, knowledge, and clinical confidence of the health workers, especially concerning effective treatment and proper primary healthcare approaches
- Share skills, knowledge, and case experiences
- Talk about the importance of collecting health information in order to better understand and serve the current community healthcare needs as well as to evaluate the effectiveness of the BPHWT programs
- Discuss the current health care situation in the field and related issues
- Insure that the necessary medicines and medical supplies are delivered to the health workers
- Instill a strong sense of confidence in the health workers so that they will be highly motivated to successfully implement their BPHWT responsibilities in the field

15) Capacity Building Program

In 2014, the Back Pack Health Worker Team organized three community health worker trainings, one Public Health Supervisor Training and two Auxiliary Midwife (AMW) trainings which aim to improve the health workers' knowledge and skills as well as to provide updated health information to health workers to be better able to serve their communities. Additionally, trainings and workshops are also conducted for the health workers every six months in the Back Pack targeted field areas.

In addition, two coordinators attended the Payap course which is organized by IRC/PLE and one coordinator attended Public Health training course which is organized by MTC and trainers were from PLE trainer team. All program staff, including program coordinators and finance team attended Data Utilization training which supported by CPI one in two months. HIS coordinator also organized monthly meeting for HIS staff.

15.1) Community Health Worker (CHW) Training

During this period, the BPHWT organized two community health worker training in Htay Bay Hta and one in Thaton area. The training is Basic Medical Training and lasted for six months and four-month internship at their respective clinics to apply the knowledge and skill from it. The purpose of the training is to recruit more health workers to provide healthcare services in their communities. The training objectives are:

- Provide health workers' knowledge and skills, and recruit more community health workers in local communities
- Provide healthcare services to the communities
- Improve the health situation, both preventive and curative, in communities
- Reduce the misusage of treatment within communities

The CHW training in Thay Bay Hta was conducted from 2 May to 2 November 2015. There were 90 trainees comprise of 34 men, 56 women from different field areas and 11 trainers comprise of 8 men and 3 women) from BPHWT and IRC. The purpose of the training is to enhance the knowledge of the health workers about anatomy and physiology, basics of medical theory and diseases. After the training, they have undergone four-month internship at their respective clinics to apply the knowledge and skill from it.

The Community Health Worker training in Thaton field area was conducted from 8 May to 2 November 2015. The total number of trainees were 28, comprise of 4 men and 24 women. There are 8 trainers (6 men and 2 women) who completed ToT. After the training, they also do have practical in their area as to adapt and apply these concepts in their work.

Key Course Topics:

- Anatomy and Physiology
- Universal Precaution
- Nursing Care
- First Aid and Minor surgery
    - Medicine
    - Essential drugs
- Pharmacy Management
- Primary Health care concept and principle
- Basic Obstetrics and Gynecology
- Primary Eye Care
- Public Health

15.2) Certificate in Public Health 3rd Batch Training

During this period, the Back Pack Health Worker Team (BPHWT) organized the 3rd batch of certificate in public health Training. This is six months training including field trip to schools and community. This certificate in public health Training started on 4 April and completed on 28 August 2015 at the BPHWT head quarter office in Mae Sot. There were 38 participants, comprised of 14 women and 24 men from different areas and ethnicities. This training was conducted by the trainers from IRC/PLE and MTC.
The BPHWT also has training team to be involved in the training as trainers' assistant. This training is an

Certificate in Public Health training in Mae Sot

advance level and focuses on prevention program. The purpose of the training is to qualify and improve health workers knowledge as to supervise other workers in their field areas. Moreover, they have to organize health education training to educate workers both prevention and treatment program. All the trainees must to complete CHW and Medic refresher before attend this training. Since they have to know the detail of the clinical diagnosis and technical method of prevention, the IRC/PLE training team has organized the training and divided the topics as below:

- First Aid
- Management on Minor Ailments
- Safe Water Supply
- Sanitary Excreta Disposal
- Garbage and Refuse Disposal
- Disposal of Sullage Water
- Rodent Control
- Vital and Health Statistics
- Epidemiological Surveillance and Control of Communicable Diseases
- Specific Communicable Diseases Control
- Malaria Control
- Filariasis Control
- Tuberculosis Control
- Leprosy Control
- STI Control
- Trachoma Control
- Health Education
- School Health
- Family Health Care
- Community Health Care
- Nutrition Promotion
- Health Management and Supervision
- Expanded Program on Immunization (EPI)

Certificate in public health Training Course Criteria for Participants:

- Completed community health worker training
- At least 2 years working experience as a health worker
- Recommended by their community or the mother organization
- At least one woman from each area
- Must be a health worker who is currently responsible for a Back Pack team
- At least 3 years working experience as a Back Pack health worker
- Be interested in primary healthcare

15.3) Auxiliary Midwife training

The 5th Batch AMW training in Pa An

The BPHWT continuous supporting of the Auxiliary Midwife (AMW) training that has been running since 2013 funded by SV award. The BPHWT with Phlon Education Development Unit (PEDU) and State Health Department (SHD) organized two Auxiliary Midwife trainings. The BPHWT has organized five batches of trainings and comprised of 27 participants who are from Hlaing Bwe & Kawkareik and Kyar In Seik Kyi townships. This training was organized from 18 May to 21 August 2015. There are currently 107

AMWs trained. The trainers of this AMW training are from Back Pack Health Worker Team (BPHWT), Karen State Department of Health (KSDoH), IRC/PLE and retired Burma Government medical personnel.

This training is focus on maternal child healthcare as to know how to deliver baby systemically include practical and theory. After the training, the trainees have to do three month internship at Mae Tao Clinic at Reproductive Health (RH) department. The key course topics of the AMW Training Course:

- Basic anatomy and physiology
- Basic nursing care
- Basic first aid
- Universal precaution
- Basic history taking and physical examination
- Common diseases (Diarrhea, ARI, Malaria, worm infestation, Measles, anemia, Vitamin deficiency)
- Anatomy and physiology of reproductive
- ANC, Delivery, PNC, abortion, < 5 year Care, IMCI, PHC concept and approach.

15. 4) Auxiliary Midwife training follow-up workshop

The BPHWT with IRC/PLE organized an Auxiliary Midwife training follow-up workshop on 21-23 July 2015 in Pa An. The facilitators are from BPHWT, IRC/PLE, and Karen State Department of Health. There were forty-eight AMWs participated in this workshop. The BPHWT had planned to distribute the kits for them, but according to funds shortage, there is not enough kit for them. It restricts them to continue working effectively in their respective areas.

Facilitators:

- Saw Win Kyaw (BPHWT)
- Dr. Kyaw Swar Myint (Karen State Health Deputy-Director)
- Dr. Aung Kay Tu (IRC/PLE)
- Nai Aye Lwin (BPHWT)
- Naw Thaw Thi Paw (BPHWT)
- Dr. Thant Zin (IRC/PLE)

Objectives:

- To share update information and set up work plan for AMW's
- To improve knowledge and skill
- To more understanding among coordination and cooperation process
- To support facilities and create job descriptions

Discussion topics:

- AMW project (BPHWT)
- Experience sharing from AMW
- Discussion on ANC and experience sharing
- Discussion on High Risk Pregnancy and experience sharing
- Discussion on High risk pregnancy and safe delivery (including EmOC)
- Discussion on PNC and experience sharing
- Discussion on New Born care and immunization with experience sharing
- Discussion on Family Planning with experience sharing
- Discussion on Common Diseases in Pregnancy with experience sharing
- Discussion on Service Mapping and Future Plan
- Discussion, Recommendation with Action Plan

15.5) Trauma Management Training:

This Training management training began on 13rd April 2015. This training included one month. Both of theory and practical at mutraw district. There were 28 participants, comprised of 20 men and 8 women. The trainees were trained by BPHWT senior trainer. The key course topics are:

- Chain of survival
- Triage and referral system
- Shock and shock trauma action plan
- Check injuries management
- Limbs injuries and landmine injuries management
- Universal precaution
- Local anesthesia and ketamine general anesthesia

16) Health Convergence Initiative

Spurred by the ongoing peace process in many ethnic areas of Burma, the BPHWT and other ethnic health organizations (EHOs)/health community-based organizations (HCBOs) have been working to converge this extensive border-based health system with the other ethnic health systems inside Burma and the Burma Government's health system to provide better health care, access more of the population, improve health systems and policy, and gain Burma Government recognition/accreditation of border-based health organizations and their workers. This is a slow process as convergence needs to occur at the system, policy, structural, and program levels, and be aligned with progress in the ongoing ceasefire and peace negotiations between the Burma Government and the ethnic armed organizations (EAOs).

This collaborative initiative began in May 2012 with the establishment of the Health Convergence Core Group (HCCG) consisting now of nine EHOs/HCBOs:

- Backpack Health Worker Team (BPHWT)
- Burma Medical Association (BMA)
- Chin Public Affairs Committee (CPAC)
- Karen Department of Health and Welfare (KDHW)
- Karenni Mobile Health Committee (KnMHC)
- Mae Tao Clinic (MTC)
- Mon National Health Committee (MNHC)
- National Health and Education Committee (NHEC)
- Shan State Development Foundation (SSDF)

The aim of the HCCG is to prepare existing ethnic community-based health networks, both inside Burma and those managed from the Burma border areas, for future possibilities to work together with Union and state/region government health agencies, ethnic authorities, international donors, international non-governmental organizations (INGOs), and civil society organizations. The purpose of the HCCG is to explore policy options for achieving the convergence of ethnic health networks with the health system of the Burma Government through political dialogue. Potential outcomes of convergence:

- Increased access to health care for populations in need
- Ethnic and community-based health programs are supported and strengthened
- Positive impact on peace building
- Basic needs and human rights are addressed
- Recognition and accreditation of ethnic health workers
- Increased decision-making and power sharing at the state/region and local levels
- International partnerships and networking are promoted

In looking at both the health system of the Burma Government and that of the Burma border-based managed EHOs, it is seen that the Burma Government health system is highly centralized while those of the border-

based managed EHOs/HCBOs are decentralized. Within this context, the HCCG has been looking at various global health system models:

- **Centralized/deconcentrated health systems:** The government is responsible for the health care of the people - curative, promotive, preventative, and rehabilitative.
- **Devolved health systems:** The government and the people are both responsible, to varying degrees depending on structure, for the health care of the people – curative, promotive, preventative, and rehabilitative.

From these health system studies, devolved health systems, especially primary health care, seem most compatible with the situation in Burma as they are more community-based, more responsive, and more in line with the aspirations of the ethnic people. Also devolved health systems appear to be the accepted global model.

The BPHWT has been moving forward with convergence activities at the program level; convergence at the policy, system and structural level will develop in conjunction with the ceasefire/peace process and as a durable, meaningful political change occurs in Burma. These ongoing initiatives with both Union and state/region health officials in Burma include:

- Expanding immunization programs
- Addressing the emergence of drug-resistant malaria
- Expanding the reproductive and child health workforce
- Information sharing on health indicators
- Health worker recognition and accreditation
- Procurement strategies
- Overlaps and gaps in programs, protocols, and target areas
- Pilot convergence activities (e.g., Auxiliary Midwife Program)
- Mutual recognition of health infrastructures
- Meetings and workshops
- Concept of health convergence

As an aspect of health convergence, the BPHWT has supported the Auxiliary Midwife (AMW) training that began in 2013. The BPHWT with Phlon Education Development Unit (PEDU) and the Karen State Department of Health (KSDoH) have, to date, organized five trainings for 107 AMWs. The 5th Batch of AMW training began on 18 May 2015. There were 27 participants who are from Hlaingbwe, Kawkareik, and KyarIn Seik Kyi Townships.

The AWM training consists of three months of classroom theory and three months of clinical internships/training in the Reproductive Health Department at the Mae Tao Clinic in Mae Sot, Thailand. Following the clinical internships/training, the new AMWs are sent back to their respective communities to implement a Maternal and Child Healthcare Pilot Program planned by the BPHWT. The AMW trainers were from the BPHWT, KSDoH, and IRC/PLE as well as retired Burma Government medical personnel. At the end of the training, the AMWs typically receive AMW kits and medical supplies. Also they were given accreditation certificates signed by the Directors of the KSDoH, PEDU, and BPHWT.

The BPHWT, with the IRC/PLE, organized an AMW Training Follow-up Workshop on 21-23 July 2015 in Pa An with facilitators from the BPHWT, KSDoH, and the IRC/PLE. There were forty-eight AMWs who participated in this Workshop. The BPHWT had planned to distribute AMW kits to them; but due to a funding shortfall, there were insufficient kits for them. Unfortunately, such a situation restricts the AMWs from working effectively in their respective service areas.

During the 2015, the BPHWT has hosted and participated in a number of HCCG activities:

1. HCCG Convergence Presentation at the Ethnic Nationalities Affairs Center (ENAC) Conference *Humanitarian Aid Policy*: 20 January 2015, Chiang Mai, Thailand.
2. HCCG Convergence Presentation to the United Nationalities Alliance: February 2015, Rangoon, Burma.
3. HCCG Convergence Presentations in the United States of America: February 2015, selected US cities – Boston, New York City, Washington DC, Seattle, and Los Angeles.

4. HCCG Convergence Presentation to the *Consulting Meeting on Sustainable Development and Peace between Border Based & Inside CSOs, and Ethnic Armed Organizations*: 2 -4 April 2015, Chiang Mai, Thailand.

5. HCCG Convergence Presentation at the ENAC Conference *Consulting with Civil Society on Health and Education Policies*: 24 – 25 April 2015, Chiang Mai, Thailand.

6. *Federal Devolved Health System for Burma/Myanmar* Presentation at the Karen Unity Seminar: 7 May 2015, Lay Wah, Karen State, Burma.

7. HCCG Consultation Meeting: 14 - 15 May 2015, Mae Sot, Thailand.

8. Health Policy and System development meeting: 11-12 December 2015, Queen Palace, Mae Sot, Thailand.

The health convergence activities of the BPHWT and the other EHOs/HCBOs can be greatly enhanced by INGOs and international donors through:

- Exploring funding opportunities that support health convergence and the peace process (e.g., joint funding for programs in Burma Government- and EAO-administered areas, cross-border funding, etc.).
- Ensuring that healthcare services and development aid are delivered in alignment with ethnic groups' needs and in a way that supports the peace process.
- Considering how planned projects may support program, system, or policy convergence.
- Recognizing the EHOs/HCBOs and their experience, skill sets, workers, and capacity built up over past 25 years and supporting them as the primary service providers in their respective ethnic areas.
- Encouraging the participation of EHO/HCBO leaders in coordination meetings, workshops, and related activities in respect to health care and health sector reform in Burma.
- Promoting and directly supporting ethnic and community-based health programs through financial support, capacity building, technical assistance, and supplies.

Such action by INGOs and international donors would greatly enhance the successful convergence of ethnic and Burma Government health systems for the benefit of all the people of Burma and serve as another "*Bridge for Peace*" in the ongoing peace negotiations.

The health convergence initiative works in concert and supports the ceasefire and peace negotiations between the Burma Government and the ethnic people. While supporting these negotiations, the movement and timing of health convergence entails certain real risks to ethnic health workers and infrastructures should the negotiations breakdown and fighting resume. With the signing of a Nationwide Ceasefire Agreement by some of the ethnic armed organizations, the risks to the ethnic health workers and infrastructures maybe somewhat lessen and more comprehensive health convergence activities can be delivered safely to targeted populations. With the election victory of the National League for Democracy, that the new Burma Government and Parliament will actively support genuine peace negotiations with the EAOs such that the active conflicts will cease on a true nationwide basis in Burma to ameliorate the associated negative health outcomes.

17) Monitoring and Evaluation

The Back Pack Health Worker Team organizes program activities meetings twice a year and a general meeting once a year, which include a monitoring and evaluation session. During these meetings, the Leading Committee specifically focuses on monitoring and evaluation. The Leading Committee monitors and analyzes data brought back from the field (e.g., caseload data and field in-charge reports) by looking at the presentations provided by the Program Coordinators. This allows for discussion on improvements which need to be made to the programs. During these meetings, Program Coordinators also offer advice on some health issues which the health workers could not solve by themselves, and then provide some suggestions for future planning.

In 2007-2008, the BPHWT conducted an Internal Programming Improvement Project (IPIP) in order to evaluate the improvement of its activities, focusing in particular on communications, appropriate drug use, and performance reviews of the clinical logbooks. In 2008, the BPHWT continued the IPIP process and the evaluation of program implementation to improve the quality of drugs administered, health workers' skills and knowledge, and logistics management.

In addition, the table shows the key indicators, methods and period of the BPHWT's monitoring and evaluation. The BPHWT also coordinate with Health Information System Working Group (HISWG) to conduct Eastern Burma Retrospective Mortality Survey (EBRMS) in every four years. The last EBRMS result report is "The Long Road to Recovery".

During 2015, the Director of Executive Board and Leading Committee members made eight monitoring trips to Dooplaya, Win Yee, Shan, Thaton, Papun, Pa An, Kler Lwee Htoo, and Mon targeted field areas to assess the situation, program effectiveness, and the health need in the field areas. There are detailed reports for each monitoring trip.

Table 17: Framework of Monitoring and Evaluation

Key Indicators	Methods	Period
Health Worker Performance	Logbook reviews	Every six months
Program Development	Annual report comparing planning and actual activities	Once a year
Program Management	Leading Committee elections and Executive Board appointments	Every 3 years
Outcome and Impact Assessment	Conducting surveys	Every 2 years
Training Effectiveness	Pre- and post-test examinations	Every year
Financial Management	Comparisons of planned and actual budgets	Every six months
	External audits	Once a year

Back Pack Health Worker Team - Log Book Review for Three Diseases (Diarrhea, Malaria, and Pneumonia)

Sampling method

Using systematic random sampling: from the sampling frame, a starting point is chosen at random, and thereafter at regular intervals according to caseloads.

Sample size estimation

$$n = \frac{Z2\alpha/2\ P\ (1 - p)}{d2}$$

$$n = \frac{1.962 \times 0.5 \times 0.5}{0.072}$$

Where n = Sample size
z = the reliability coefficient (confidence level) at 95% CI = 1.96
p = proportion of population which yield the largest sample size
= 0.5
d = absolute precision of study = 0.085 (acceptable error)
n = 196 (200)

Feedback on log book review & Health System Strengthening field assessment

BPHWT Log Book Review:

- BPHWT & IRC-PLE staffs reviewed
- Log Books recorded during 2015
- Two main diseases – Diarrhea and Pneumonia
- Total 200 samples were reviewed for each disease
- Reviewed during December 2015

Nine Different areas:

1. Yee
2. Dooplaya

3. Kler Lwee Htoo
4. Papun
5. Thaton
6. Kawkareik
7. Mergue/Tavoy
8. Kayan
9. Special

Areas covered in each disease:

- Proper recording of signs & symptoms of the patients
- Proper recording of vital signs
- Correct diagnosis
- Treatment according to guideline

Table 18: 2012 – 2015 result (scoring – fair and above)

Pneumonia (%)				Diarrhea (%)			
2012	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
93% 186/200	89% 178/200	94.5% 189/200	91% 182/200	26.5% 53/200	58% 116//200	97% 194/200	84% 168/200

Pneumonia

- Duration of symptoms & no record from physical examination (32%)
- Body weight was not recorded in some areas
- Misdiagnosed (Severe P'nia but no severe s/s)
- Treatment was not relevant with diagnosis and physical examination
- No vit-A supplementary in some patients

Diarrhea

- Treatment not relevant with diagnosis
- Few records on signs of dehydration
- Diagnosis was not included level of dehydration
- Duration of s/s
- Body weight and blood pressure were not recorded in vital signs

18) Program Development and Activity Reviews in 2015

Comparison of Planned and Actual Activities (Logistical Framework Activities)

Overall goal	To reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary healthcare						
OBJECTIVES	**ACTIVITIES**	**INDICATORS OF ACHIEVEMENT**	**VERIFICATION SOURCES**	**2015 EXPECTED RESULTS**	**2015 ACTUAL RESULTS**	**VARIANCES OR DIFFERENCES**	**ASSUMPTION OR RISKS**
Medical Care Program							
1. Provide essential drugs and treat the common diseases	To maintain the existing BPHWT teams	No. of teams existing	Procurement delivery documents; logbooks; analysis of data collected; and field reports	100 BP teams	100 BP teams		
	Provide medicine and medical supplies	No. of target population and total case-load (w/m), under/over 5)		200,000 targeted population	244,410 covered population 44,419 HHs M - 118,422 F -125,988 <5 -46,046 >=5- 198,364		It can be more targeted population because of some of the refugees might back to their village according to the current situation
	Treat common diseases and minor injuries	No. of cases treated (w/m, under/over 5)		100,000 cases being treated (w/m and under/over 5)	82,260 cases M-37,859 F-44,401 <5-15,633 >=5-66,627		
	Provide ITNs	No. of ITNs provided and no. of HHs and people receiving ITNs	ITNs distributing lists & annual report	40,000 ITNs will benefit 40,000 HHs	27,600 ITNs for 17,977 HHs		One households have more than one family.
		Percentage of people in households sleeping under ITNs (Baseline-	2016 Impact Assessment Survey	65% of people in households sleeping under ITNs	N/A		

		53%)					
	Provide malaria rapid tests	No. of malaria rapid tests provided	Rapid tests distributing lists	32,400 rapid tests will be provided	32,400 rapid tests		
	# of Malaria treated	Number of (CASES) women and men diagnosed Pf & Pv malaria with Rapid tests	logbooks; field in-charge reports; midyear and annual report	Women – 4,000 Men - 4530 Total: 8,530 individuals	W – 1,034 M - 1,269 T - 2,303		Malaria case decreases in the field areas.
		Malaria mortality rates per 1,000 population (baseline-3.5 malaria case deaths per 1000 population)	2016 Impact Assessment Survey	2.2 malaria mortality rates per 1,000 population	N/A		
		Mortality rates among children under 5 years old per 1,000 live births in target population (baseline-138)	2016 Impact Assessment Survey	130 mortality rates among children under 5 year old per 1,000 live births in target population	N/A		
		Percentage of under 5 children with malnutrition (according to accepted guidelines for MUAC cutoffs) (Baseline – 16.5%)	2016 Impact Assessment Survey	14% of under 5 children with malnutrition	N/A		
2. Respond to disease	- Purchase emergency	Prompt reporting Population	Delivery document;	-Effective response and treatment for	- Provided assistances to		For the detail information,

outbreaks and emergency situations	medical supplies and immediately take action	affected No of cases treated (w/m, under & over 5)	field reports; exception reports; annual report	disease outbreaks or emergency situations (w/m & under/over 5	victims from fighting, flooding, land confiscation, & cholera outbreak		please see EART reports and cholera outbreak report
3. Improve health workers skills and knowledge	Organize Field meetings and workshops	No. of field workshops and meetings		Twice a year for 20 areas	35 field workshops 29 field meetings		
		No. of health workers participated	Field meeting and workshop report	300 people participate in field workshop and 300 in meeting (15-20 participants in each workshop or meeting)	344 (M-166/F-178) attended field workshop 306 (M-183/F-123) attended field meetings		
	Organized six month regional workshops and meeting	No. of field health workers participated in the program workshop and meeting	Workshop report; mid-year and annual report; workshop attendance list	100 health workers attend six month regional workshops and meeting (w/m)	100 health workers (F-55/M-45)		
4. Improve patient referral systems	Refer patients to the nearest hospitals or clinics.	No of referrals patients(w/m) List of referral sites	Mid-year and annual reports; patient's referral for	30 patients referred to clinics or hospitals (w/m) including EMoC cases	132 patients referred (F-41/M-77) and 14 EmOC cases		The BPHWT could provide some financial support for referral, so there were more patients referred than expected.

Community Health Education and Prevention Program							
1. Reduce the incidence of malnutrition and worm infestation	Distribute de-worming medicine to children between 1 to 12 years	No. of children receiving de-worming medicine	Worker data form; mid-year & annual reports	35,000 children will receive de-worming medicine	T-14,402 W-7467 M-6935		Budget limitation
	Distribute Vitamin A to children between the ages of 6 months to 12 years	No. of children receiving Vitamin A		40,000 children will receive Vitamin A	41,282 (Boy –20,248, girl – 21,034)		
2. Educate students and communities about health	Provide school health education	No. of school health sessions and no. of students (w/m)	Field reports; mid-year & annual report	90 sessions attended by 9,000 students (w/m)	90 sessions 30,691 students (B – 14,831/ G-15,860)		
	Organize Village Health Workshops	No. & category of people in Village Health Workshops (w/m)		9,500 people participate in 95 Village Health Workshops	T - 6, 813 M -3, 034 W – 3,779 97 workshops		
3. Improve community level knowledge and participation in health	Organize village health worker trainings and workshops	No. training and VHW attended (w/m)	Field report; mid-year & annual report; VHW training and workshop reports	10 VHW trainings for 200 new VHWs (w/m)	No VHW trainings		Budget limitation
		No. workshop and VHW participate (w/m)		180 VHW workshop for 592 trained VHWs (w/m)	No VHW workshop		Budget limitation
4. Improve water and sanitation systems in the community to reduce water-borne diseases	Provide water and sanitation systems	No. of latrines built and No. of HHs benefit from latrines	mid - year & annual report	1,500 community latrines or will be benefited 1,500 HHs	817 latrines 1,022 HHs		
		No. & type of water systems installed	mid - year & annual report	20 gravity flow water systems 1,200 house-holds (6,000 pop)	18 gravity flow installed for 1,948 HHs		

		No. of HHs and people benefit from water systems (w/m)	mid - year & annual report	35 shallow well systems 400 house-holds (2,000 pop)	9 shallow wells installed for 235 HHs		
		% of people who own a latrine using latrines (always and sometimes) (Baseline -98%)	2016 Impact Assessment Survey	99% of people who own a latrine using latrines (always and sometimes)	N/A		
		% of people who own a latrine (Baseline - 70% in 2010)	2016 Impact Assessment Survey	85% of people who will own a latrine	N/A		
Maternal and Child Healthcare Program							
1. Increase maternal and child healthcare	Distribute de-worming medicine	No. of pregnant women receiving de-worming medicine	TBA's form, mid -year & annual report	4,000 pregnant women will receive de-worming medicine	3,042 pregnant women received de-worming medicine		No Vitamin A distributing to postpartum women according to WHO protocol and guideline
	Provide iron prenatally and postnatally to pregnant women	No. of pregnant women and women receiving iron	TBA's form, mid -year & annual report	4,000 pregnant women and women will receive iron	3,226 pregnant women and women will receive iron		
	Referral of serious obstetric cases	No. of serious obstetric cases	Patient's referral form; mid - year & annual report	10 obstetric cases referred	14 obstetric cases referred		

	Provide ANC to pregnant women	No. and % of pregnant women in target population with at least four ANC (Baseline – 44.7% in 2010)	2016 Impact Assessment Survey	55% of pregnant women in target population with at least four ANC	N/A		
		% of children 0-5 months who are fed exclusively with breastfeeding in target population (Baseline -23%)	2016 Impact Assessment Survey	35% of children 0-5 months who are fed exclusively with breast milk in target population	N/A		
		No. and % of Trained Traditional Birth Attendants who can identify at least 3 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines(Baseline -45% -2010)	2016 Impact Assessment Survey & TBA assessment	55% of TBAs/TTBAs who can Identify at least 5 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines	N/A		
2. Raise awareness among villagers on family planning and provide them with family	Provide family planning supplies	No. of clients receive the family planning supplies (w/m)	Mid - year and annual reports	4,500 people using family planning methods (w/m)	4,926 (207) people used FP		
	Provide family planning education	% of people using family planning methods	2016 Impact Assessment Survey	35% of people are using family planning methods	N/A		Traditional cultural barriers

planning supplies	Provide family planning pamphlets	No. of pamphlets provided	Distributing list, mid-year & annual report	10,000 family planning pamphlets will be provided	No FP pamphlets was provided		Budget limitation
	Conduct TTBA training	No. of new TTBAs complete the training	mid-year & annual report	6 TTBA training for 240 people (w/m)	4 TTBA trainings attended by 64 (M-1/F-63)		
	Conduct TBA/TTBA workshops	No. of TBA/TTBA Follow-up Workshops held & no. of TTBAs attending (w/m)	mid-year & annual report	150 follow-up TBA/TTBA Workshops for 750 TBAs/TTBAs (w/m)	104 TBA/TTBA workshops attended by 555 (M-57/F-598)		
	Provide safe birthing kits	No. of births attended by trained TBAs/TTBAs and health workers, among total target population % of births attended by trained TBAs/TTBAS % of births attended by health workers (Baseline – TBA -67%, health worker – 27%)	TBA's/TTBA's form; mid-year & annual report 2016 Impact Assessment survey	- 4,000 babies delivered by trained TBAs/TTBAs and health workers - 60% of births will be attended by TBAs/TTBAs 35% of birth will be attended by health workers	3,341 babies delivered by trained TBAs/TTBAs and health workers 73% of birth attended by TBAs/TTBAs & 24% by MCH workers		Currently, more TTBAs are trained This % is based on routine data 2015.
		No. of TBA/TTBA kits provided	Kits distributing list; midyear & annual report	1,700 TBA/TTBA kits	1,200 TBA/TTBA kits		
		No. of maternity kits provided		5,250 maternity kits	4,200 maternity kits		

		Appropriate sterile instrument (new razor blade, sterile scissors, etc) = 326 (79%)-2010, povidine/lodine or other antiseptic = 354 (85%) -2010	2016 TBA assessment survey	- 85% of new razor blade, sterile scissors, and etc were used - 90% of povidine/lodine or other antiseptic were used	N/A		
		At the last pregnancy that you delivered provide at least 3 information = 353 (85%) -2010	TBA Assessment Survey	- 90% of postpartum women were given at least 3 information	N/A		
4. Provide delivery records	Document deliveries	No. of newborn baby received delivery records	Delivery record issued copies, midyear and annual report	2,000 delivery records	2,196 delivery records		
5. Converge and coordinate with the Burma government's state administered Reproductive healthcare program in Karen State.	Organize Auxiliary Midwife Training and workshop	No. of AMW training provided	AMW training report & attendance list	1 Auxiliary midwife training will be provided	1 Auxiliary midwife training was conducted		
		No. of AMWs participate in the training		25 AMWs will participate	27 participants (all women)		
		No. of AMW workshop organized	AMW workshop report &	2 AMW workshops will be organized	1 AMW workshop		

		No. of AMWs participate in the workshop	attendance list	20 AMWs participate in each workshop	48 AMWs		
	Provide AMW kits	No. of AMW kits provided	AMW training report & attendance list	110 kits for 75 AMWs	No AMW kits provided		Budget limitation
	Organize EmOC trainees	No. of EmOC trainees	Mid & annual report	8 EmOC trainees	8 EmOC trainees		
	Provide EmOC supplies	No. of EmOC supplies provided	Mid & annual report	8 EmOC supplies will be provided	No EmOC supply provided		The supplies were distributed on clinic based
Capacity Building							
1. Improve health worker and staff knowledge and skills	CHW training	No. of trainees completed CHW training (w/m)	CHW training report & attendance list	2 CHW trainings for 70 CHW (w/m)	3 CHW trainings attend by 118 CHWs (w-80/m-38)	- 1 more CHW training - 48 more CHWs trained	More requirement from the communities
	MCH refresher training course	No. of trainees complete training (w/m)	MCH training report & attendance list	1 MCH refresher training course for 30 MCH	1 MCH refresher training attended by 30(M-5/F-25)		
	Certification in Public Health Training (CPH)	No. of trainees complete training (w/m)	Training attendance list & report	1 CPH training for 30 health worker (w/m)	1 CPH attended by 38 (M-24/W-14)		
	Technical refresher training (Malaria & EPI)	No. of trainees complete the training (w/m)	Training attendance list & report	2 Technical refresher training for 60 people (w/m)	1 AMW follow-up workshop attended by		The BPHWT has changed this topic to AMW follow up workshop.

					48 AMWs		
	Attend international conferences and meeting	No. of times and participants in international conferences & meeting	Mid - year & annual report	Attend 2 international conference or meetings attended by 2 staff members	1 LG member attended 1 intentional conference		
	Attend local conferences and meeting	No. of times and participants in local conferences & meeting	Mid - year & annual report	6 local conferences or meeting will be attended by 8 staff members	9 staff attended 17 local conferences and meetings		
	Attend international and local short course training	No. of participants attend short course training	Mid - year & annual report Attendance list	4 staff members will attend short course training	4 LG members attended 2 trainings		
	Organize organization development training	No. of participants attend OD training	Attendance list	10 staff members will attend OD training	2 staff attended OD training		
	Organize project management training	No. of participants attend project management training	Attendance list	10 staff members will attend project management training	2 staff attended project management training		
	Organize internship program	No. of participants		60 staff members will attend internship program	63 interns (W-51/M-12)		
2. Promote gender equality in leading positions	Review adopting policies	% of women leading health programs	Field report & staff list	At least 30% of women leading health programs	57%		
		% of women field in-charges	Field report & staff list	At least 30% of women field-in charge	44%		

		% of women in leading committee	Annual report & staff list	At least 30% of women in leading committee	46%		
	Hold the BPHWT general selection triennially	% of women was elected	Annual report & staff list	At least 30% of women in leading committee	46%		
Health Information and Documentation							
1. Assess and document community health situation and needs	Produce HID materials	No. of digital cameras and no. of video cameras provided	HID staff report	20 digital cameras and 2 video cameras will be provided	7 digital cameras and no video cameras		
2. Standardize health data collection processes	Analyze data collected by health workers	Frequency of analysis	Six months workshop report	Twice a year	2 times		
		No. of participants		10 participants each time.	8 participants		
3. Make evidenced based health status comparisons with the target community	Organize field meetings and workshops	No. of field meetings or workshops provided	Field meeting and workshop report	Twice a year for 19 areas	35 field workshops 29 field meetings		
		No. of participants		300 people participate in field workshop and 300 in meeting	344 (M-166/F-178) attended field workshop 306 (M-183/F-123) attended field meetings		
4. Raise awareness of the community health problem	Produce health information, education and communication materials	No. of health information and communication (IEC) materials provided	IEC distributing list; village health workshop	10,000 FP pamphlets provided	No FP pamphlets provided		

			report form				
5. Advocate local and international organizations about the health situation in Burma	Organize health program coordination and development seminars	No. of seminar	Annual report	At least once a year	1 HCCG meeting		
		No. of participants	Annual report	30 people will participate in the seminar	64 (W-26/M-38) participants		
	Provide T-shirts	No. of T-shirts provided	Annual report	1,500 T-shirts will be provided	No T-shirt		Budget limitation
Program Management and Evaluation							
1. Monitor and evaluate the programs' improvement	Conduct impact assessment survey	Frequency of impact assessment survey conducted	2016 Impact Assessment survey report	Once every two year	N/A		This survey will be conducted in 2016
	Conduct monitoring trip	No. monitoring trips and no of staff	Mid-year & annual report	3 monitoring trips in a year	8 monitoring trips		This can be according to the strategy for organizing the regular meeting
	Conduct six months meeting	No. of health workers attend the six months meeting	Mid-year & annual report	100 health workers attend the six months meeting	100 health workers (F-55/M-45)		
	Provide Leading Committee meetings	No. of Leading Committee meetings provided	Office records	2 Leading Committee meetings per year	3 Leading Committee meetings		
	Provide Executive Board meetings once in a month	No. of Executive Board meetings provided	Office records	12 Executive Board meetings per year	10 EB meetings		
	Provide staff meetings	No. of staff meetings provided	Office records	24 staff-meetings per year	18 staff-meetings		
Health Convergence							
1. Converge the	Standardize	No. of seminars	Attendance	Twice in a year	MCH		With BMA, MTC,

extensive border-based health system with the Burma government's health system	curriculum between border-based health CBOs	and meetings No. of participants	list		coordinator attended 4 meetings		KDHW
	Health program convergence between border-based health CBOs and the MOH Burma	No. of seminars and meetings No. of participants No. of field visits	Attendance list	Twice a year			Only AMW training conducted in Pa An. No other health program convergence with MOH.
	Health system convergence between the border-based health CBOs/ EHO and MOH Burma	No. of seminar and meetings No. of participants	Attendance list	Twice a year	Health Policy and System Development Meeting attended by 40 (W-15/M-25) participants		But there was no MOH.
	Organize Auxiliary Midwife Training	No. of AMW training provided No. of AMWs participate in the training	AMW training report & attendance list	1 Auxiliary midwife training will be provided 25 AMWs will participate	1 AMW training for 27 participants		

19) Back Pack Health Worker Team Financial Report – 2015

ITEMS	Income (Thai Baht)	Expenditure (Thai Baht)	%
OPENING BALANCE -1 JANUARY 2015	4,314,788		…
PERIOD INCOME			
Burma Relief Centre(IP/ CIDA)	1,461,778		6%
Burma Relief Centre /SIDA	1,000,000		4%
Burma Relief Centre /NCA	1,054,571		5%
International Rescue Committee (IRC)	4,785,271		21%
Stichting Vauchteling (SV)- Netherlands	3,606,144		16%
Thai Border Consortium (TBC)	2,000,000		9%
Burma Relief Centre /Just Aid foundation	-		0%
Open Society Foundation	2,857,829		13%
Burma Relief Centre /TdH Germany	734,049		3%
Community Partners International/SDC	2,084,062		9%
Burma Mission Humanitarian (BHM)	550,000		2%
Mainly I Love Kids (MILK)	2,455,000		11%
Other Donation	193,180		1%
Bank Interest	11,206		0%
TOTALPERIOD INCOME	**22,793,089**		**100%**
TOTAL INCOME	**27,107,877**		
PERIOD EXPENDITURES			
Back Pack Medicine and Equipment(MCP)		6,015,704	23%
Back Pack Field Operation Supplies and Services		3,159,100	12%
Community Health Education and Prevention Program(CHEPP)		3,733,786	14%
Maternal and Child Health Care Program(MCHP)		3,225,626	12%
Capacity Building Program(CBP)		3,612,299	14%
Health information and Documentation (HID)		249,203	1%
Program Management and Evaluation(PME)		2,595,333	10%
General Administration		3,847,329	15%
TOTAL PERIOD EXPENDITURES		**26,438,380**	**100%**
CLOSING BALANCE - 31 December 2015		**669,497**	

Part II: Program Workshops & 35rd Annual Meeting Report – 2016

A. Program Workshops and training:

1.1) Medical Care Program Workshop
1.2) Community Health Education and Prevention Program Workshop
1.3) Maternal and Child Healthcare Program Workshop
1.4) Malaria Workshop
1.5) Mental Health Integrated in to Primary Health Care workshop
1.6) Family Planning workshop
1.7) Logbook Review Feedback and Pharmacy Management workshop
1.8) Treatment Guideline workshop
1.9) Organizational Development (OD) Training
1.10) Gender Mainstreaming workshop
1.11) Reporting writing workshop
1.12) TTBA ToT workshop

1. 35th General Meeting of the Back Pack Health Worker Team

1) Program Workshops

During the BPHW's annual meeting in 2016, there were three main program workshops -Medical Care Program Workshop, Community Health Education and Prevention Program Workshop, and Maternal and Child Healthcare Program Workshop, eight other related Workshops and one training of organization development.

1.1) Medical Care Program Workshop

Facilitator - Naw Hsa Mu Na Htoo (MCP coordinator), & Dr. Aung Phyi Phyo
Duration - 6-9 March 2016
Participants - 37 (25 men and 12 women)

Discussion Topics:

- MCP in-charge presentation
- Review report forms
- Review data from reports (Field In-Charge Report, Worker Report, VHW Report /Medicine Inventory, & Other Reports)
- Update the stationary BP in each area
- Malaria Treatment update protocol (Myanmar + SMRU)
- Review malaria and general medicines
- Review program meeting and workshop recommendations

1.2) Community Health Education and Prevention Program Workshop

Facilitator - Saw Eh Mwee (CHEPP Coordinator)
Duration - 9-10, & 11 March 2016
Participants - 17 (15 men and 2 women)

Discussion Topics:

- Review CHEPP objectives
- Review village health workshop
- Review data and forms
- Water and sanitation water systems
- School health
- Vitamin A and De-worming medication
- Future plans

1.3) Maternal and Child Healthcare Program Workshop

Facilitator - Thaw Thi Paw, Sarbrina, Collage Paw and Leh Nay Say
Duration - 9, 10, 11 and 13 March 2016
Participants - 44 (3 men and 32 women)

Discussion Topics:

- MCHP supervisor presentations
- Maternal death case study (4 cases APH,PPH,PPH, Obstructive labor)Win Yee, Pa Pum,Kayan
- Introduction of Zika virus infection
- Nutrition
- Financial review
- Future plans

1.4) Malaria Workshop

Facilitator - Dr. Aung Phyi Phyo (SMRU)
Duration - 9-10 March 2016
Participants - 72 (32 men and 40 women)

Discussion Topics:

- Treatment option
- Drug resistant
- Recommendation (control, containment program, elimination and PCR method)
- Malaria guideline
- Rapid Diagnosis Test –RDT

1.5) Mental Health Integrated in to Primary Health Care workshop

Facilitator - Dr. Mu Yel Pen (OSI) and Dr. San San Oo (OSI)
Duration - 12-13 March 2016
Participants - 67 (25 Men and 42 Women)

Discussion topics:

- Definition of Mental Health
- Mental illness
- Common mental health program
- Priority condition common mental disorder
- Sub control (Health education)

1.6) Family Planning workshop

Facilitator - Dr. Seik Naing
Duration - 12 March 2016
Participants - 66 (23 Men and 43 Women)

Discussion topics:

- Program introduction
- Prevention of ultra-cancel
- Caesarian Section operation
- Advocacy
- Mobile outbreak
- Application (poster, Pamphlet)
- Service strategies

- Sexual reproductive
- Unwanted pregnancy

1.7) Logbook Review Feedback and Pharmacy Management workshop

Facilitator - Dr. Tharaphi Aung
Duration - 15 March 2016
Participants - 81 (36 men and 45 Women)

Discussion topics:

- Review of malaria
- Review of Pneumonia
- Review of diarrhea
- Review of arthritis
- Review of ARI
- Review of hypertension
- Review of diabetes
- Review of worn infection

1.8) Treatment Guideline workshop

Facilitator - Dr. Tharaphi Aung
Duration - 14 March 2016
Participants - 68 (25 Men and 43 Women)

Discussion topics:

- Introduction of treatment guideline
- Focus on Pneumonia, Malaria and Diarrhea

1.9) Organizational Development (OD) Training

Facilitator - Nang Snow
Duration - 22-23 March 2016
Participants - 28 (21 Men and 7 Women)

Discussion topics:

- What is project?
- What is project management?
- Project cycle management
- Logical Framework

1.10) Gender Mainstreaming workshop

Facilitator - Khun Chakkrid (Protection Coordinator-IRC/PLE)
Duration - 21 March 2016
Participants - 49 (17 Men and 32 Women)

Discussion topics:

- Concept of Protection Mainstreaming
- 4 key element of protection mainstreaming
- Protection Mainstreaming Tools
- Protection Mainstreaming Guidance Note for health sector (1)
- Protection Mainstreaming Guidance Note for health sector (2)

1.11) Reporting writing workshop

Facilitator - Ko Gyi Kyaw
Duration - 8 March 2016
Participants - 62 (29 Men and 33 Women)

Discussion topics:

- Types of reports
- Effectiveness report writing
- Report Analysis
- Report writing outline
- Practice report writing
- Edit the report

1.12) TTBA ToT workshop

Facilitator - Naw Thaw Thi Paw
Duration - 24-26 March 2016
Participants - 17 (all Women)

Discussion topics:

- Reviewing training objectives
- Planning for TTBA training
- Discussing trainer's skills and ability
- Reviewing how to arrange and prepare for the training
- Discussing about lesson plans
- Practicing how to teach for TTBA training

Organizing Program workshops during annual meeting in Mae Sot

2) 35th Annual General Meeting of the Back Pack Health Worker Team

The 35th Back Pack Health Worker Team annual meeting was conducted from 16 to 17 March 2016 in Mae Sot at the BPHWT head office. Attending this meeting were 100 staff members – 45 men and 55 women. A week before the beginning of the meeting, the BPHWT's data team entered, checked the quality of, and analyzed the data obtained from the field. The data were discussed in program meetings before being discussed in the general meeting. During the general meeting, the Leading Committee discussed the data within a programmatic perspective in order to monitor events taking place in the field. After this analysis, they discussed how to improve data collection methods.

35th Annual General Meeting

During the meeting, the Leading Committee members also offered advice for any issues that health workers could not solve by themselves, and provided input and suggestions to plans for the next period of implementation. The purpose of the meeting was to discuss health workers' experiences in the field, share knowledge, review which activities were and which were not implemented as well as why some activities could not be implemented, compare outcomes in relation to plans made at the previous six-months meeting, and share difficulties encountered in field. After the meeting, the Leading Committee discussed possible ways to handle the problems identified during the workshop and came to decisions about how to take action to solve these problems.

1) Schedule of BPHWT's 35th annual General Meeting:

Day (I) { 16 March 2016 }	
Description of Presentation	**Responsibility**
Opening Speech	Dr. Cynthia Maung
Introduction	Facilitators
Review and Discussion about the 34th Six Monthly Meeting and the Last Executive Board Meeting Decisions	All members of the BPHWT
MCHP Coordinator's Report & MCHP Workshop Report	Naw Thaw Thi Paw
MCP Coordinator's Report & MCP Workshop Report	Naw Hser Mu Nar Htoo
CHEPP Coordinator's Report & CHEPP Workshop Report	Saw Eh Mwee
Day (II) { 17 March 2016 }	
Field updated situation report	Ko Gyi Kyaw
Health Information and Documentation report	S' Aung Than Oo
Capacity Building Program Report	Saw Del Del
Office Administration Report	S' Moe Naing
Financial Report	Saya Chit Win
Conclusion of Meeting Decisions	Facilitators
All Other Business	All members of the BPHWT
Closing Speech	Saw Win Kyaw

2.2) 35th General Meeting Decisions:

1. There will be a discussion in the Leading Committee and Field in-Charges Meeting about the health worker assessment.

2. The BPHWT made the decision to conduct a two day workshop about the diseases of hypertension, pneumonia, arthritis (DU/PU peptic ulcer), neonatal jaundice and diarrhea after the 35th General Meeting.

3. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about conducting the BPHWT strategic planning workshop.

4. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about implementing an EPI pilot program.

5. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about the requests made by the field areas.

6. The MCP Coordinator is responsible for developing and distributing referral forms to field areas.

7. The BPHWT made the decision to speak with the MTC about MCH certificates for those MCH workers who have completed MCH training at the MTC and were to attend midwife training.

8. The MCP Coordinator is responsible for organizing a workshop about the collecti on of mortality data in the field areas.

9. The BPHWT made the decision to distribute 350 handbooks to the field areas about the treatment of under five children.

10. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about the AMW assessment and related future plan.

11. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about the recruitment of Assistant CHEPP Coordinator.

12. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about the common essential medicine list.

13. The CHEPP Coordinator is responsible for collecting a listing of existing gravity flow water systems, shallow wells, and latrines that have been installed by the BPHWT in each field area.

14. The HID Coordinator is responsible for collecting data for service mapping and there will be a discussion in the Leading Committee and Field in-Charges' Meeting about the selection of attendees for this service mapping workshop.

15. S' Aung Than Oo and S' skel will attend the ARC GIS training which will be organized by the HISWG.

16. The BPHWT made the decision to conduct Impact Assessment Survey during the second six month period of 2016 with the HID Coordinator responsible for tits implementation.

17. The BPHWT made the decision to conduct Community Health Worker training in Thay Bay Hta and the Mon and Kayah Field Areas.

18. Thara Chit Win is responsible for organizing a malaria workshop, in coordination with the URC, during the third week of May 2016.

19. The BPHWT made the decision to organize mental health training, coordinated with the Open Society Foundation (OSF), in May 2016.

20. The 2015 financial report presentation was approved during this 35th General Meeting.

Recording:

1. Naw Dah Shi replaces Naw Moo Lar Paw as a health worker on the Kalaw Hta Back Pack Team in the Papun Field Area.

2. Saw Dee Wah replaces Saw Eh Soe as a health worker on the Htee Tha Blu Hta Back Pack Team in the Papun Field Area.

3. Naw Eh May Paw, Naw Say Eh, and Saw Par Shi are appointed as health workers on the Ka Thaing Tee Back Pack Team and Naw Eh May Paw is appointed as a Back Pack Team in-Charge in the Papun Field Area.

4. Saw Thu Kaw and Naw Paw Say are appointed as health workers on the Tel Boe Hta Back Pack Team and Saw Ba Khin is appointed as a Back Pack Team in-Charge in the Papun Field Area.

5. Naw Dah Bie replaces Naw Mu Kay as a health worker on the Hto Lel Wah Kee Back Pack Team in the Dooplaya Field Area.

6. Nant Mya Mya Sein replaces Saw Ar Dah as a MCP Health Worker on Htee Kalay Back Pack Team in the Pa An Field Area.

7. Naw Ka Naw replaces Naw Eh Thar Soe as a MCH Supervisor in the Mergue/Tavoy Field Area.

8. Moe Naing Soe replaces Joe Wah Nee as a MCP Health Worker on the Chi Taung Back Pack Team in the Kayah Field Area.

9. Khaing Soe Phaing, a health worker in the Arakan Field Area, died on 17 October 2015 while providing health care during fighting in his area of operations.

10. The Ta Oh Kee Back Pack Team in the Thaton Field Area will be transformed into a Stationary Back Pack Team during the first six month period of 2016.

11. Daw Moe Moe Sein, a TTBA on the Kayaw Back Pack Team the Kayan Field Area, died on 1 March 2016 due to retained placenta during her delivery.

12. Daw See Sakar, a TBA on The Tha Yu Back Pack Team in the Kayah Field Area, died on 23 October 2015.

Leading Committee and Field In-Charges' Meeting's Decisions:

1. The BPHWT made the decision to collect human resource data during the first six month period of 2016 with the HID Coordinator responsible for this process.
2. The BPHWT made the decision to conduct the BPHWT's strategic planning workshop at the end of May 2016 with Nai Aye Lwin responsible for leading this workshop.
3. The BPHWT made the decision to implement an EPI pilot program in some of the BPHWT field areas in Karen State.
4. The BPHWT made the decision for implementing the Back Pack Teams during the first six month period of 2016 according to the following table:

No.	Field Areas	Pilot BP Teams	Permanent BP Teams
1	Pa An	1	7
2	Papun	3	9
3	Thaton	0	7
4	Kawkareik	0	3
5	Dooplaya	0	7
6	Win Yee	0	4
7	Taungoo	0	5
8	Kler Lwee Htoo	0	7
9	Mergue/Tavoy	1	6
10	Yee	0	6
11	Moulamein	0	6
12	Kayah	0	7
13	Kayan	2	5
14	Special	0	3
15	Shan	0	6
16	Pa O	0	2
17	Palaung	1	5
18	Kachin	0	4
19	Naga	0	2
20	Arakan	0	3
21	Chin (WLC)	1	0
	Total	9	104

5. The BPHWT made the decision to distribute two units of emergency medicines for the Palaung Field Area during the first six month period of 2016.
6. The BPHWT made the decision to organize a Leading Committee meeting with the Burma Relief Centre (BRC) about the meeting at the BPHWT on 19 March 2016 with some community leaders in a Chin area of the Sagaing Region for the training and formation of mobile medics.
7. Regarding the request for urine sticks from the field areas, the MCP Coordinator is responsible for getting technical assistance in respect to the use of urine sticks during the second six month period of 2016.
8. The BPHWT made the decision to distribute eighty-four sets of medical instruments, thirty-five adult weight scales, and thirteen cameras during the first six month period of 2016.
9. The BPHWT made the decision to conduct village health worker (VHW) training in the Pa An and Papun Field Areas during the first six month period of 2016.
10. The BPHWT made the decision to support 200,000 THB for CHW training in the Mon Field Area and 250,000 THB for CHW training in the Kayah Area during 2016.
11. The BPHWT made the decision to contribute to the transportation of CHW trainees in Thay Bay Hta according to the following table; these trainees must arrive at the BPHWT office in Mae Sot on 31 March 2016.

No	CHW	Participant	Travelling Cost	Unit	Amount	Remark
1	Palaung	5	4,500	5	22,500	
2	Naga	6	4,500	6	30,000	
3	Arakan	8	5,000	8	40,000	
4	Kachin	4	5,000	4	20,000	
5	Special	3	5,000	2	10,000	Hpa-an (1)
6	Palaung (TSYO)	5	4,500	5	22,500	
	Total	**31**	**29,000**		**150,000**	

No	Medic	Participant	Amount (Baht)
1	Palaung	1	7,500
2	Naga	1	7,500
3	Kayan	1	7,500
4	Kachin	1	7,500
5	Special (Pa An)	1	2,000
6	Palaung (TSYO)	1	7,500
		6	39,500

12. One medic, including a Field in-Charge, from each Field Area will attend mental health training organized by the Open Society Foundation (OSF) in May 2016. Thara Chit Win is responsible for contacting the OSF for this training.
13. The BPHWT made the decision to conduct TTBA training in the Kayan, Yee, Arakan, Palaung, Dooplaya, and Pa O Field Areas during the first six month period of 2016.
14. The BPHWT made the decision to organize seventy TBA/TTBA workshops and distribute fifty TBA/TTBA kits during the first six month period of 2016.
15. The BPHWT made the decision to provide personal hygiene kits for school health activity during the first six month period of 2016.
16. The BPHWT made the decision to implement water and sanitation systems according to the following table:

No.	Field Areas	Community Latrines	Shallow Wells	Gravity Flows
1	Mergue/Tavoy	100	0	0
2	Pa An	150	0	3
3	Kler Lwee Htoo	0	1	0
4	Yee	150	0	1
5	Kayah	200	4	0
6	Kayan	150	0	1
7	Papun	0	10	4
8	Shan	150	0	2
9	Dooplaya	100	2	3
10	Special	0	2	0
11	Arakan	200	0	0
12	Kachin	0	1	0
13	Palaung	80	0	0
14	Win Yee	0	1	0
15	Naga	0	0	1
	Total	**1,280**	**21**	**15**